The Vermont Long-Term Care Plan:

A Demonstration Waiver Proposal to the Centers for Medicare and Medicaid Services

October 1, 2003

Department of Aging and Disabilities
103 South Main Street
Waterbury, VT 05671-2301
Voice/TTY (802) 241-2400
Fax (802) 241-2325
http://www.dad.state.vt.us

The Vermont Long-Term Care Plan:

A Demonstration Waiver Proposal

Table of Contents

EXECUTIVE SUMMARY

The State of Vermont has a long history of significant health care reform and expansion of health coverage for its uninsured residents. Building on the substantial achievements of the Vermont Health Access Plan Demonstration Waiver, the State is now turning its focus to the long-term care arena. This proposal for a long-term care demonstration program is the result of a year-long planning and development initiative. The proposed program addresses both shortcomings in service availability and the inherent bias in the current funding mechanisms for long-term care.

This Demonstration is aimed at giving adults with physical disabilities and the frail elderly real choices. That means giving them the option to receive the long-term care services they need in a home- and community-based setting without having to wait for a "slot" to open up in a 1915(c) waiver program, or to choose care in a nursing facility. Individuals who can maintain themselves in the community, with home- and community-based services should have that option. Often, under the existing federal Medicaid system, this important goal cannot be achieved. Therefore Vermont is proposing a bold new approach to the delivery and financing of long-term care services for adults with physical disabilities and the elderly.

The long-term care program described in this Demonstration Waiver proposal will constitute a wholesale replacement of most of Vermont's existing Long-Term Care Medicaid program. All individuals currently eligible for Medicaid and in receipt of long-term care services in a nursing facility, HCBS Waiver or ERC Waiver, will be enrolled in the demonstration. The program will be administered by the Department of Aging and Disabilities, within the Vermont Agency of Human Services – the single state agency for Medicaid in the State of Vermont. It will be operated as managed care model under a global budget.

The primary goals of the demonstration are to provide consumers with equal access to long-term care options (nursing facility and home- and community-based services) and promote early intervention for at-risk populations.

The Demonstration is designed to test the hypothesis that targeted early interventions, assessment, case management and the provision of home- and community-based services to the frail elderly and physically disabled adults will:

- ensure enrollee satisfaction with the long-term care services received;
- reduce utilization of institutional settings; and
- control overall costs for long-term care in the State.

Under this demonstration Vermont will seek to create a program without institutional bias, financial or otherwise. It is specifically designed to help elders and younger adults with physical disabilities to live as independently as possible for as long as possible, in the settings of their choice.

Vermont also recognizes that funding constraints are a reality. Accordingly, it has developed a prioritization strategy which ensures that those with the "highest needs" are served first and to the full extent of their needs. The program categorizes eligibles into three distinct groups: Highest Need; High Need; and Moderate Need. High and Moderates Needs groups are further prioritized and individuals are served based on the level of available resources.

The "Highest Need" group will be entitled to either nursing facility or home- and community-based care. This entitlement to either setting represents a dramatic change in the way long-term care services are provided in Vermont. Today approximately 2,200 individuals are benefiting from the entitlement to nursing facility care. With this change in entitlement, Vermont projects that nearly 3,000 individuals will benefit from the broader entitlement to both nursing facility and HCBS by allowing the additional 800 individuals equal access to either category of service. All Demonstration participants in the Highest Need group must also meet the financial eligibility criteria for Vermont long-term care Medicaid.[1] Vermont anticipates that given equal access to either nursing facility or home-based care, more individuals will choose home- and community-based care. This will allow the State to serve more individuals for the same amount of money.

[1] The one exception is with respect to resources. Demonstration participants electing home-based services may retain up to $10,000 in resources.

The High Needs Group will not be legally "entitled" to long-term care services, but will be served to the extent that funds are available. These individuals will also have to meet existing long-term care Medicaid financial eligibility criteria,[2] but will not have care needs at a level which meets the existing clinical criteria for long-term care Medicaid. Given historical utilization, the State expects that this group will consist of approximately 200-300 individuals each year. Vermont fully expects that the individuals in this subgroup will all be served under the waiver; however, there is the remote possibility that they would not be served if there were no funds left after serving the Highest Need group. These individuals would still be eligible for the many home- and community-based and Medicaid State Plan services that would continue outside this Demonstration.

The Moderate Needs group will include individuals who do not meet current nursing facility or HCBS Waiver eligibility criteria, but are believed to be at risk of institutional placement based on their assessed care needs. Vermont believes that if services can be provided to these individuals earlier than the current practices allow, their conditions can be stabilized or improved, thus avoiding or delaying more costly institutional care. These individuals will be assessed and provided with preventive and supportive services necessary to help maintain their well being and independence. This might be as little as a weekly homemaker visit, or a monthly case management visit. They will be served to the extent funds are available after serving all eligibles in the Highest and High Need groups.

In summary, the Demonstration offers the Department of Health and Human Services and the Centers for Medicare and Medicaid Services the opportunity to test a new and innovative model of long-term care service delivery and financing. The imperative exists. There will be incredible pressure on the long-term care financing system under Medicaid as the "Baby Boom" generation ages. This demonstration has tremendous merit and will provide invaluable experience and data to assist HHS and CMS in their planning efforts and policy-making activities going forward.

[2] Ibid 1

Chapter 1: Background and Description of the Demonstration

Background

The Vermont Health Access Plan (VHAP) was implemented under the auspices of a Section 1115 Research and Demonstration Waiver granted to the State in 1995. The overarching goal of that waiver was the restructuring of the State's publicly funded health care system to maximize the number of persons with health coverage, while spending no more than would have been spent under the pre-waiver program.

Concurrent with VHAP implementation, the Vermont Legislature, in its 1995-1996 session, passed Act 160, "An Act Relating to the Coordination, Financing, and Distribution of Long-Term Care Services." Act 160 lays out the State's overall strategy for restructuring Vermont's long-term care delivery system.

Under the Act, the Agency of Human Services (AHS) was instructed to gradually reduce Title XIX nursing home expenditures during Fiscal Years 1997 – 2000 by an amount equivalent to eliminating 234 beds (or about six percent of all beds in the State). The Agency was further directed to shift the dollars associated with those reductions to fund the expansion of home- and community-based (HCB) services.

The total number of nursing facility beds in the State has declined to 3,600; a five percent reduction from their peak in 1996. Occupancy has also declined and now stands at 3,250 (90%). However, the recent decline in nursing facility utilization has now leveled off.

The relatively modest progress Vermont has made in reforming its long-term care system is now threatened by State budget problems. To help balance the State's budget, the Agency of Human Services, through the Department of Aging and Disabilities, (DA&D) may be forced to reduce funding allocated to the HCBS programs to ensure that sufficient dollars are available to finance the existing entitlement to nursing facility services. Ironically, this circumstance sets up a cycle that ensures that the ultimate goals sought by both the state and federal government cannot be achieved.

As a solution to this situation, the Vermont Agency of Human Services is proposing a broad-based program of long-term care reform. The reform program being proposed addresses both shortcomings in service availability and the bias inherent in the current funding mechanisms for long-term care.

The Legislature has authorized the Agency to seek the federal waivers necessary to support the development of a stronger, more comprehensive HCB service infrastructure within the State. The starting point was to be Vermont's existing 1915(c) waivers, two of which target elderly persons and physically disabled adults[3].

The larger of those two waivers was most recently renewed in Calendar Year 2002 and grants Vermont the authority to offer a continuum of HCB services to individuals eligible for Title XIX and found to be eligible for nursing facility level of care. The specific HCB services covered under that waiver are: case management; personal care; respite care; adult day care; companion; personal emergency response system; and assistive devices/home modifications. The waiver currently has 978 slots and serves approximately 1,500 individuals per year.

The second 1915(c) program is a model waiver authorizing enhanced residential care services for elders and younger adults with physical disabilities (Enhanced Residential Care - ERC Waiver). It was approved by the Centers for Medicare and Medicaid Services (CMS - then HCFA) in March 1996 and has since obtained status as a 5-year waiver that is capped at 200 enrollees. This waiver currently has 146 slots and serves approximately 210 individuals per year. Vermont is in the process of renewing the waiver for this program, which has operated successfully.

Eligibility criteria for nursing facility and home- and community-based services are currently the same, and all clinical eligibility decisions are reviewed and approved by the Department of

[3] Vermont also has 1915(c) waivers for MR/DD clients, for individuals with traumatic brain injury and for children.

Aging and Disabilities. The Department of Prevention, Assistance, Transition and Health Access (PATH) determines financial eligibility. Eligible consumers are given a choice between nursing facility care and the services available through the Enhanced Residential Care Waiver or Home-Based Waiver.

The State currently determines clinical eligibility for these two waiver programs using a comprehensive assessment instrument known as the "Independent Living Assessment" (ILA). The ILA captures information on an individual's functional status (ability to perform Activities of Daily Living and Instrumental Activities of Daily Living), cognitive/emotional status, health status and medical conditions, home environment, and informal social supports. A home health Registered Nurse or Area Agency on Aging case manager administers the assessment. An RN always administers the section on health status and medical conditions. The assessment is administered in collaboration with the applicant and/or family members and is designed in part to assist in selecting a service setting and range of services based on needs identified through the ILA. Final approval of the HCBS plan of care or approval for nursing facility care rests with the Department of Aging and Disabilities. The ILA is appended to this proposal at Appendix A.

The Vermont Legislature's strong commitment to expanding HCB services in the State offers a unique opportunity for testing a "preventive" long-term care model – one built around HCB services. That model is included as part of this Demonstration Waiver proposal.

The overriding goal of the proposed Demonstration is the expansion of choices for consumers. The State of Vermont is committed to offering its elderly and adult physically disabled residents a comprehensive array of options designed to deliver the services they need. Vermont intends to do this by continuing to expand and build upon its existing home- and community-based services, while at the same time continuing to ensure the availability of quality nursing facility care. The specific programmatic objectives for the Long-Term Care Demonstration project are:

- Contributing to existing research and practice regarding which functional, cognitive, and medical measures are the best early predictors of individuals at risk for institutional placement in the short to medium term.

- Testing the hypothesis that it is more cost-effective to furnish a package of HCB services to individuals, based on their specific needs, than to operate a system where there is a bias for institutional options.

- Testing the related hypothesis that a limited package of HCB services, if furnished early enough, can significantly delay or eliminate the need for nursing facility placement and result in a net savings for the State and federal governments.

- Improving the quality of life and degree of independence for low-income elderly persons and adults with physical disabilities, by helping them to maintain the highest possible degree of functioning while living at home, or in a home-like setting.

- Facilitating the further growth and development of home- and -community based services and resources throughout the State.

- Testing the effect of greater consumer control and choice on quality and cost.

Description of the Demonstration

Overview

The long-term care program described in this Demonstration Waiver proposal will constitute a wholesale replacement of most of the existing long-term care Medicaid program in Vermont. All individuals currently eligible for Medicaid and in receipt of long-term care services in a nursing facility, HCBS Waiver or ERC Waiver will be enrolled in the demonstration. This includes persons currently enrolled in the State's existing HCBS waivers and nursing facility residents, but excludes enrollees in any Program for the All-Inclusive Care of the Elderly (PACE) program that may be operated in Vermont or those persons screened out through the Pre Admission Screening/Annual Resident Review (PASARR). Vermont has also submitted a proposal to CMS for the "Vermont Independence Project- VIP", which asks for Medicare reimbursement for case management services to assist individuals to manage their chronic disease. If this program is ultimately approved, the Medicare funds associated with case management services for the approved population will be rolled into this waiver.

Future Medicaid applicants who require long-term care services will also be enrolled in the demonstration. Vermont will use its existing Utilization Review process to determine whether individual Medicaid recipients who are residents of a nursing facility at the time the demonstration is implemented have the potential for returning to a home or other community setting with HCB services.

The program will be administered by the Department of Aging and Disabilities, within the Vermont Agency of Human Services – the single state agency for Medicaid in the State of Vermont.

The goal of the demonstration is to provide consumers with choice through equal access to long-term care options (nursing facility and home- and community-based services). Vermont will accomplish this by providing equal access to long-term care services and by expanding eligibility for a variety of long-term care services for its citizens under the proposed Vermont Long-Term Care Research and Demonstration Waiver.

The provision of expanded home- and community-based services will be enacted through a new Section 1115(a) Research and Demonstration waiver program. This waiver proposal describes the expansion, its objectives, and its "fit" within Vermont's other health care reform initiatives.

The Demonstration is designed to test the hypothesis that targeted early intervention, assessment, case management, and the provision of home- and community-based services to the frail elderly and disabled adults will:

- ensure enrollee satisfaction with the long-term care services received;
- reduce utilization of institutional settings; and
- control overall costs for long-term care in the State.

In addition to the objectives previously outlined, there are also five overall goals for the proposed long-term care demonstration program, as follows:

- provide equal access to long-term care options;
- better manage the state's soaring long-term care expenditures;
- provide preventive services to an expanded group of individuals with the goal of preventing or delaying the need for more costly services;
- under a "Cash and Counseling" pilot, provide Medicaid services tailored to the consumer's unique needs and preferences, rather than what is permissible under rigid state plan rules; and
- encourage early planning for future needs, by offering financial incentives to encourage the purchase of private long-term care insurance.

Past attempts to provide consumers with meaningful options have often been thwarted, to some degree, by the very nature of the current long-term care financing mechanisms. Most notable is the inherent bias in the Medicaid program for institutional (nursing facility) care. This bias exists because nursing facility care is an entitlement, while home- and community-based services are not. Ironically, accessing the type of care and services that elders and younger adults with physical disabilities most desire, i.e. home- and community-based services that allow them to live independently, requires many individuals to get on a waiting list and hope that a waiver slot opens up soon. At the same time, the service and setting they least covet (a bed in a nursing facility) is readily available. This is the very dilemma that Vermont seeks to address.

Medicaid is the single largest funding source for long-term care in the State of Vermont and the nation. Accordingly, the reimbursement policies of that program have a tremendous impact on the availability of resources and the utilization of services. For years, the institutional bias of the program has driven supply and demand for nursing facility services, with HCB services largely relegated to relatively small waiver initiatives.

Under this demonstration Vermont will seek to change that dynamic by creating a program without institutional bias - financial or otherwise. It is specifically designed to help elders and younger adults with physical disabilities to live as independently as possible for as long as possible, in the settings of their choice.

Eligibility for the program will be similar in some respects to the eligibility requirements of typical 1915(c) Home- and Community-Based Services waivers in effect throughout the nation.

That is, eligible individuals must be residents of the State who are age 65 years or older, or those age 18 and older whose primary needs are the result of a physical disability. The program will have three eligibility levels; Highest Need, High Need and Moderate Need.

The "Highest Need" group will be entitled to either nursing facility or home- and community-based care. This entitlement to either setting represents a dramatic change in how long-term care services are provided in Vermont. Today approximately 2,200 individuals are benefiting from the entitlement to nursing facility care. Under this change in entitlement, Vermont projects that nearly 3,000 individuals will benefit from the broader entitlement to both nursing facility and HCBS by allowing the additional 800 individuals equal access to either category of service. All Demonstration participants in the Highest Need group must meet the financial eligibility criteria for Vermont Long-Term Care Medicaid.[4] Vermont anticipates that given equal access to either nursing facility or home-based care, more individuals will choose home-and community-based care. This will allow the State to serve more individuals for the same amount of money.

Vermont also proposes to create two "expansion groups" of waiver eligibles in the hope of serving more individuals than are currently being served.

The first expansion group will be created by slightly modifying current nursing facility and HCBS Waiver eligibility clinical criteria. Individuals meeting the revised clinical criteria will constitute the "High Needs" group. Members of this group will not be legally "entitled" to long-term care services, but will be served to the extent that funds are available. These individuals must also meet the existing long-term care financial Medicaid eligibility criteria[5] and the revised clinical standards for the Demonstration. Given historical utilization, the State expects that this group will consist of approximately 200-300 individuals each year. Vermont fully expects that the individuals in this subgroup will all be served under the waiver; however, there is the remote possibility that they would not be served if no funds were left after serving the Highest Need group. These individuals would still be eligible for the many home- and community-based and Medicaid State Plan services that would continue outside this Demonstration.

[4] The one exception is with respect to resources. Demonstration participants electing home-based services may retain up to $10,000 in resources.
[5] Ibid 4

The second expansion group will include individuals who do not meet current nursing facility or HCBS Waiver eligibility criteria or the clinical criteria for the High Need group, but are believed to be at risk of institutional placement based on their assessed care needs. Vermont believes that if services can be provided to these individuals earlier than the current practices allow, their care. These individuals will be assessed and provided with only those services (not covered by other funding sources) necessary to help maintain their well being and independence. This might be as as a weekly homemaker visit, or a monthly case management visit. This group will be called the conditions can be stabilized or improved, thus avoiding or delaying more costly institutional little "Moderate Needs Group". Individuals in this group will be served to the extent funds are available after serving all eligibles in the Highest and High Need groups. Vermont will designate some funds in the beginning of the Demonstration to ensure at least the provision of case management services for individuals in this group. The State will also include funds to make some Homemaker and Adult Day services available to this group. Details on the eligibility rules and enrollment procedures are discussed in Chapter 2 of this document.

Demonstration Design

The Demonstration is designed to maximize choice for consumers who need long-term care by creating equal access to nursing facility and home- and community-based services for all Medicaid long-term care recipients. The hypotheses is that when equal access to services exists, more individuals will choose home- and community-based services, thereby freeing up funds to provide preventive services to eligible individuals with somewhat lesser needs in the hope of delaying or preventing the necessity of institutional care.

The proposed Long-Term Care Demonstration program is comprised of a series of key components. Each component provides a critical building block for constructing a comprehensive, consumer-centered long-term care system. Each component contributes not only to the integrity of the overall system but to its fiscal soundness and sustainability as well.

Each of the nine components is described below. State staff executes some of the components, while others are carried out on the State's behalf by local organizations. The first component – the Statewide Educational Initiative – is a centerpiece of the overall program. From there the

program flows through a process of referral intake and preliminary assessment, enrollment in the Demonstration (if eligible), a thorough evaluation of clinical and social support needs, the development of a comprehensive care plan and the associated budget for its execution, and an ongoing process of monitoring and updating the plan based on changes in an individual's needs and circumstances.

Program Components

Statewide Educational Initiative

A series of educational programs will be directed at providing individuals and their families with complete, unbiased information on the range and type of long-term care services available in the community, and the funding sources and eligibility criteria for government-sponsored programs. The Vermont Department of Aging and Disabilities will employ various media to provide outreach and education statewide with respect to the long-term care demonstration program. These broad-based initiatives will be specifically designed to ensure the dissemination of information throughout the state, and will not necessarily be targeted just to Medicaid eligible individuals. The participation and support of private practice physicians and other health care professionals will also be sought. DA&D intends to do extensive outreach with physicians and other health care professionals in the community to educate them about the Demonstration and to encourage referrals of patients with long-term care needs to the program.

Individuals will be informed about the long-term care services covered under the waiver for Demonstration participants. Potentially eligible persons will be informed that nursing facility care is covered under the Demonstration only if such care is medically necessary, given the individual's condition and circumstances. If an individual becomes eligible to participate in the Demonstration during the course of a stay in a nursing facility and an independent evaluation indicates that the nursing facility level of care is not medically necessary, the cost of the nursing facility will not be reimbursed by Medicaid under the Demonstration, unless no other appropriate placement is available. In such cases, discharge planning will continue.

Referral Intake and Preliminary Assessment Process

This process will occur at the time the individual is identified as potentially requiring long-term care services. Referrals for preliminary assessments can come from a variety of sources including self-referrals, family members and friends, physicians, community agencies, hospitals, or other providers. Individuals do not have to be eligible for the Demonstration to receive assessment services.

During the assessment process, persons are screened for potential eligibility for the Demonstration by DA&D staff. Those individuals who are not eligible for the Demonstration will be referred to the appropriate local agencies for further assistance in locating community-based resources.

All persons being discharged directly to nursing facilities from hospitals within the State of Vermont will be assessed in the nursing facility, if they convert from Medicare or Private Pay to Medicaid as their source of payment. Individuals who have Medicaid as a payment source at the time of admission will be assessed either before or shortly after admission. State staff will make every effort to assess Medicaid eligible persons prior to discharge from a hospital, but assessment will not delay appropriate discharge. During that assessment, nursing facility residents and families will be informed about the Long-Term Care Demonstration program, its eligibility criteria, and the covered benefits and services it provides. As part of its Utilization Review function, Vermont will continue to conduct intermittent evaluations, during the nursing facility stay to assess a resident's ability to opt for home- and community-based care.

If the individual opts for home- and community-based services, a certified case manager will assist the individual in making the transition from the nursing facility to the home or other alternative residential setting.

Enrollment into the Demonstration

Elders and younger adults with physical disabilities who meet the clinical and financial eligibility criteria will be enrolled in the Demonstration. The State will initially raise the limit on

resources from $2,000 to $10,000 for enrollees electing home-based services. Persons with resources above $2,000 will be responsible for copayments for their services as described later in this Chapter. The retention of a higher level of monetary assets will address the concerns of many elders and younger adults with physical disabilities who continue to maintain themselves in the community and periodically need to expend cash assets to maintain their home. Those who have these concerns have identified a very low level of resources ($2,000) as a barrier to accessing the Demonstration. Vermont believes that considering its overall objectives for this Demonstration, a $10,000 resource limit is more appropriate for persons opting for home-based services. The $10,000 limit seems reasonable when taking into consideration certain home maintenance costs, i.e. roofing, furnaces, hot waters heaters and other essential items. Enrollees who require nursing facility care or Enhanced Residential Care services must continue to spend down their resources to the current $2,000 level before becoming eligible for Medicaid coverage. Knowing that the functional status of individuals might improve while they are in the nursing facility and that individuals frequently move between nursing facility care and home-and community-based care, Vermont is researching the possibility of protecting an individual's assets (up to $10,000) for up to a 30-day stay in a nursing facility. This would allow the individual to have the necessary resources to return to the community if s/he is able.

In addition to raising the limit on resources for individuals enrolling in home-based services, Vermont will implement Presumptive Eligibility for Demonstration enrollees. After receiving a referral, DA&D staff will conduct an assessment of both the individual's clinical and functional status, as well as his/her financial circumstances. DA&D staff will determine clinical eligibility at that point. Based on information provided about the individual's financial situation, DA&D staff may deem the individual presumptively eligible. This will enable the consumer to receive needed services while the final eligibility determination is being made by PATH. Presumptively eligible enrollees who mislead or misinform DA&D with respect to their financial situation will be held liable for the cost of any services provided during the presumptive period. Based on historical experience, DA&D expects very few instances where persons found presumptively eligible are ultimately determined to be ineligible.

Once it is determined that the individual is eligible to enroll in the Demonstration, a DA&D staff member will conduct an initial assessment of his/her clinical and social support needs. This

initial assessment will drive the determination of clinical need and the development of the initial Care Plan. DA&D staff will also determine if the enrollee is to be included in the Demonstration's Highest Need group. Highest Need group members include those individuals who are determined to be in need of extensive or total assistance with ADLs, have complex medical needs and need daily nursing care. Individuals who do not meet these criteria will be enrolled as members of one of the Demonstration's Expansion groups (High Need or Moderate Need), depending on the results of their clinical assessments.

Once an individual is enrolled in the Demonstration as a member of the Highest Need group, he/she will receive all necessary covered long-term care services through the 1115 waiver program. This Demonstration program will not affect eligibility for Medicaid-covered State Plan services.

Individuals enrolled in the Demonstration as members of the High and Moderate Need groups will receive long-term care services only in the amount that can be financed under the waiver. This may include a partial service plan under the Demonstration coupled with other services available in the community outside of the waiver, including, home health services covered by Medicare or the Medicaid State Plan, dementia respite grants, senior center services, Older Americans Act services such as congregate meals, home-delivered meals and case management, and the DA&D Housing and Supportive Services program.

Evaluation of Individual Enrollee Clinical and Social Support Needs

As described above, once the DA&D staff determines that the individual meets the criteria for the Highest Need Group, the individual is assisted in making the choice of nursing facility or home- and community-based care. If nursing facility care is chosen, DA&D will forward the initial assessment and notice of presumptive eligibility to the facility and to the Department of Prevention, Assistance, Transition and Health Access (PATH).

If the individual chooses care in a home- or community-based setting, the enrollee will be asked to select a case management agency (one of 12 regional home health agencies or one of five Area Agencies on Aging.) The certified case manager from the selected agency will then

complete a comprehensive assessment using the DA&D Independent Living Assessment Tool (Appendix A). The evaluation includes an assessment of the person's physical and mental status, his/her social support system, living arrangements, need for assistance with activities of daily living and instrumental activities of daily living.

Development of Individual Comprehensive Care Plans for each Enrollee

Once the certified case management completes the comprehensive assessment, an individualized care plan will be developed. DA&D staff will review these plans. The assessment and plan of care will be updated at least annually for those enrolled in the Demonstration and more often if warranted by changes in the enrollee's situation or condition. Any subsequent changes in care plans will also be submitted to DA&D staff for approval. The enrollee is considered to be an active participant in the care planning process and will be notified of any modifications to his/her plan. Enrollees who wish to appeal a modification (reduction) in services may do so according to existing Medicaid appeal procedures.

The care plan includes an array of services based on the need determined using data from the comprehensive assessment, and the individual's status as a Highest Need, High Need or Moderate Need enrollee. Case management services, personal care or attendant services, respite care, enhanced residential care, assisted living and nursing facility services, adult day health care services, assistive devices and home modifications, companion services, and personal emergency response systems may be included in the care plan. The plan will also include informal supports, other appropriate Medicaid State Plan services and home- and community-based services. The plan will specify not only the services to be provided, but also the quantity in which they are to be provided and the provider designated to deliver each service.

Individuals in the High and Moderate Need groups who are not currently receiving services due to a shortage of available funds under the Demonstration will still be eligible for other non-Medicaid services available in the community, Medicaid State Plan Services and Medicare services. All Demonstration enrollees, including those in the Expansion Groups – High Need and Moderate Need groups - (if they are eligible for Community Medicaid) will be eligible for case management services. Those enrollees who are being served, but perhaps not to the full

extent of their needs, will also be directed to other community-based resources. Appendix D to this document lists the services available outside of the Demonstration Waiver.

Enrollees and/or their designees will be encouraged to participate in the care plan development process. The enrollee and his/her designee will also sign off on the care plan, indicating acceptance of the services contained therein.

The Department of Aging and Disabilities will audit the care plan development process to ensure its integrity. DA&D will also monitor, directly or indirectly, the delivery of services under the care plans and will track the proportion of services included in the plan that are actually delivered to the enrollee.

Nursing facility services will be included in the care plan if the individual meets the clinical eligibility criteria and the individual or his/her legal representative has chosen this long-term care setting. Health and welfare issues are central to any decision with respect to the need for nursing facility care, and will be considered as part of the assessment process.

Only those services included in an enrollee's comprehensive care plan are reimbursable by Medicaid under this demonstration. There will be no reimbursement for "off-plan" services. The cost of any long-term care service provided outside the plan of care is the financial responsibility of the enrollee. Some substitution of services will be allowed for those in the Cash and Counseling pilot, but each individual service must be listed in the comprehensive care plan. Acute care services and services rendered on an emergency basis are covered in accordance with the provisions of the Vermont State Medicaid Plan. The comprehensive care plan will also include a back-up care plan in the event of an emergency.

Development of a "Cash and Counseling" Pilot

Vermont will develop a pilot, initially in one or two counties, to test the efficacy of a "Cash and Counseling" Program. Individuals will be assisted by certified case managers in the development of a comprehensive care plan and budget to support that plan. Certified case managers will help determine the appropriateness of this option for an individual, based on

his/her assessment and other screening tools developed for this purpose. The certified case manager will provide counseling and support to consumers who have elected and been approved to participate in the pilot. A workgroup, with many consumer members, has been convened to help design the details of the pilot using information gleaned from the results of the three Robert Wood Johnson Foundation pilot states.

All other Demonstration enrollees will receive assistance from their case managers in arranging for the services called for in the care plan.

DA&D expects that by Year 2 of the demonstration these pilot programs will expand significantly with large-scale consumer-directed initiatives operating throughout the State.

Ongoing Monitoring and Modification of the Care Plan and Corresponding Budget

For individuals residing at home or in an adult foster family care home (a residential alternative under development by DA&D), certified case managers will meet, face-to-face, with each Demonstration enrollee at least monthly. During these meetings, case managers will conduct informal assessments of the enrollee's ability to be maintained in the community given his/her current level of support. They will monitor for any change in the enrollee's condition that would necessitate a formal re-assessment of the enrollee. They will also identify any service delivery issues, or new problems that have not been addressed.

Periodic, formal reassessments are conducted of each individual enrolled in home- and community-based services to ensure that the services being provided are adequate and appropriate. Reassessments will be conducted at least annually and more often if there is a significant change in the individual's status. Enrollees residing in nursing facilities, Enhanced Residential Care Homes and assisted living residences will also be periodically reassessed according to existing regulations, using the existing assessment tools. For nursing facilities, this is the MDS. For Enhanced Residential Care Homes and assisted living residences, Vermont uses an MDS-like assessment tool (see Appendix E). As the individual's circumstances change over time, reassessments will be completed, care plans will be modified and new budgets will be developed.

Vermont will continue to ensure the health and welfare of each enrollee. Demonstration enrollees who might not otherwise appear eligible for nursing home care, but who, due to emergency circumstances, require that setting for their health and welfare, will receive nursing facility care, at least temporarily. Emergency admission is defined as a situation in which an individual is likely to experience death or serious and permanent harm unless admitted to a nursing facility, or when admission to the facility was from a hospital emergency room.

Also, if an individual is admitted to a nursing home, and then improves and is no longer eligible for that setting, but for whom no safe alternative can be found, then she/he may remain in the nursing facility until a safe setting for discharge can be arranged. This is the current practice in Vermont, although it is rarely invoked.

Quality Monitoring and Management Program

Vermont's Department of Aging and Disabilities has developed a comprehensive program for monitoring the level and quality of services provided to Demonstration enrollees, which will be expanded under this proposal. Chapter 4 of this proposal describes those initiatives.

Long-Term Care Ombudsman Program

Vermont will expand its current Long-Term Care Ombudsmen program to make it a true long-term care program covering the full range of services provided under the Demonstration, not just nursing facilities and enhanced residential care homes. The Ombudsmen will be available to receive and investigate complaints regarding services rendered under the Demonstration, providing third party oversight of the program. They will also serve as consumer advocates.

Encourage Early Planning and the Purchase of Private Long-Term Care Insurance

Vermont will evaluate ways to encourage individuals to purchase long-term care insurance as a way to help reduce the burden on the State and Federal budgets. It will explore financial incentives such as State tax credits or income deductions . Vermont is in the process of

completing the development of its long-term care insurance regulations. DA&D will work with the long-term care insurance industry, the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), and other interested parties to research methods to encourage the purchase of long-term care insurance. Vermont will also develop a public information initiative to inform consumers about long-term care insurance.

Program Administration

The Department of Aging and Disabilities (DA&D) will serve as a capitated long-term care managed care plan under this waiver. The Agency for Human Services, the single state agency for Medicaid, will provide a global budget to DA&D, which will be determined based on the historical per-member-per-month fee-for-service equivalent cost of the current long-term care program times the total number of enrollees expected under the Demonstration. This will ensure that the Agency assumes responsibility for the cost of services to individual enrollees, and the number of persons served under the waiver.

In order to ensure appropriate management of costs, DA&D will provide oversight of the development of the comprehensive care plans developed for each enrollee by the certified case managers and provide technical assistance as needed. Projected expenditures will be continuously monitored based on the budgeted cost of each care plan. DA&D will use its Services, Accounting and Management System (SAMS) and DAILCare databases in concert with the EDS claims payment system to track program financials and budgets.

The actual claims cost for services provided under the Demonstration will be continuously compared with the projected expenditures under the aggregate budgeted cost of all care plans for enrollees. These comparisons will be reported by DA&D to the Office of Vermont Health Access on a quarterly basis. When actual expenditures exceed the projected care plan-based aggregate budget by more than two percent (annualized) in any given month, a Corrective Action Plan will be developed and implemented by DA&D.

DA&D will reserve a portion of the program funds upfront to provide case management and a limited range of preventive services for the High and Moderate Need groups. Once savings

begin to accumulate under the Demonstration, DA&D will use some of those funds to further expand services to these two groups under the Demonstration. This will include persons who do not meet the State Plan eligibility criteria for the Medically Needy program and are not SSI-eligible. Once service delivery to the High and Moderate Need groups begins, DA&D will be at risk for the cost of these enrollees to the extent that total costs exceed the Federal budget neutrality limit.

The expansion of services to the High and Moderate Need groups will be done incrementally to ensure that the program can be sustained. Populations targeted for enrollment in the Moderate group will include persons who do not currently require HCB services to remain in the community, but who are at risk of reaching that stage within 12-24 months if some level of intervention does not occur. Determination of who is at-risk will be made through the application of the State's initial assessment. Individuals in the High Need group will be served before allocating dollars to services for the Moderate Need group (other than for case management and a limited range of preventive services). Mechanisms will be developed to prioritize individuals within each group to ensure that services are provided first to those most in need.

A portion of the savings achieved under the Demonstration will also be used to increase the breadth and volume of services available in underserved communities. For instance, DA&D may seek to increase reimbursement for residential care homes/assisted living residences to entice new providers into the market and encourage existing providers to expand capacity. Similarly, DA&D will consider providing grants to expand adult day health center capacity. In that event, DA&D will be the grantor. It will also consider ways to expand programs to prevent caregiver "burn-out" (e.g. the Dementia Respite Program). This program provides caregivers with the financial resources to take "time-out" from the day-to-day responsibility of caring for certain Demonstration enrollees, particularly persons with dementia.

Demonstration Enrollee Cost Sharing

Demonstration enrollees will be subject to modest cost sharing. There will be copays for certain HCB services. Copays will be tiered based on the enrollee's income.

Income above the 300 percent SSI level will disqualify the individual financially, although individuals who meet the clinical criteria for the Highest and High Need groups may spend down to that level to qualify for services under the Demonstration. In the Highest and High Need groups, individuals will be subject to the Long-Term Care Medicaid patient share provisions of the existing Medicaid program. Individuals in the Moderate Needs group must spend down excess income in accordance with the methods use for the State's medically needy program prior to being found eligible for the Demonstration.

Individuals otherwise eligible for the Demonstration, but who have resources between $2,001 and $10,000 will be enrolled in the program, but will only receive home- based services; not Enhanced Residential Care or adult family foster care (should DA&D develop that residential option). These enrollees with resources between $2,001 and $10,000 will be required to make copayments for services in recognition of their additional monetary assets. Vermont is considering copayments in the range of $50-$100 per month, depending on the actual resources determined during the eligibility process. Copayment levels will be adjusted annually at recertification based on the individual's financial circumstances at that time. Individuals will be required to report the acquisition of any new financial resources, which would result in their total resources exceeding $10,000. Individuals with resources between $2,000 and $10,000 who move from home-based care to an institutional setting (including Enhanced Residential Care Homes), must spend down their excess resources before the institutional care can be paid for under the Demonstration.

Chapter 2: Eligibility and Enrollment

Financial eligibility criteria for the Demonstration will be the same as for the current Medicaid Long-Term Care program, except that a higher level of resources will be permitted for enrollees who elect home-based care. The Caseload Estimates presented in Chapter 5 project months of eligibility based on historical trends in Medically Needy, SSI and Blind/Disabled adult populations in the program. Three Medicaid Eligibility Groups (MEGS) are presented: Highest Need; High Need; and Moderate Need. The Cost Estimates also include the historical per recipient per month costs.

The State will serve members of the Highest Need group on an entitled basis. These individuals must be found eligible for long-term care Medicaid under all existing eligibility criteria – clinical and financial, including restrictions on transfer of assets. These individuals will be allowed to spend-down excess income and resources to meet the financial eligibility requirements. They will also be permitted to retain up to $10,000 in resources if they elect to be served at home.

The State will also sponsor an expansion eligibility category referred to as the High Need group. The High Need group will include individuals who meet the current long-term care financial eligibility requirements, but not necessarily the existing clinical long-term care requirements. They must, however, meet the clinical requirements for the High Need group under this Demonstration. These individuals will be allowed to spend-down excess income and resources to meet the eligibility requirements. However, the individuals in this group are not legally entitled to services under the Demonstration. Individuals in the High Need group are also permitted to have up to $10,000 in resources if they elect home-based care.

Finally, the State will sponsor a second expansion eligibility category known as the Moderate Needs group. The income and resource requirements are the same as those for the Highest and High Needs groups; however, no spend-downs will be allowed. The individuals in this group will have to meet the clinical criteria for the Moderate group; however those criteria will be less intense than the criteria for the other groups. These individuals will not have a legal entitlement to Long-Term Care services.

They will receive services only to the extent that funding is available. Their eligibility will be determined using a streamlined application form with self-declared income and resources.

The following table depicts the eligibility groups under the Demonstration.

Waiver Medicaid Eligibility Group (MEG)	Highest Need Group	High Need Group	Moderate Need Group
Physically disabled adults meeting current Medicaid LTC eligibility standards	√	√	
Physically disabled adults who do not meet current Medicaid LTC clinical eligibility standards but meet the Demonstration Clinical Criteria and the financial criteria for LTC Medicaid			√
Medically Needy adults who meet current LTC eligibility standards	√	√	
Medically Needy adults who do not meet current LTC eligibility standard but meet the Demonstration Clinical Criteria and the financial criteria for LTC Medicaid			√
Dual Eligibles who meet current LTC eligibility criteria	√	√	
Dual Eligibles who do not meet current LTC eligibility criteria but who meet the Demonstration Clinical criteria and the financial criteria for LTC Medicaid			√

NOTE: Current Medicaid LTC eligibility standards refers to those eligibility criteria in place prior to the implementation of this LTC Demonstration Project.

Table 2 below summarizes the financial eligibility criteria and benefit coverage. Chapter 3 contains the details with respect to covered services and the service delivery system.

Table 2

Demonstration Eligibles	**Highest Need**	**High Need**	**Moderate Need**
Income	300% of SSI	300% of SSI	300% of SSI
Resources	$2000/$10,000[6]	$2000/$10,000[7]	$2000/$10,000[8]
Benefit Coverage[9]	All LTC Services (entitled to all medically necessary and appropriate services covered under the Waiver)	LTC Services based on available funding	LTC Services based on available funding[10]

To the extent that the Demonstration produces savings, these funds will be used to expand the amount and array of services available to these groups. As savings accumulate further, the State may also further expand the eligibility criteria to allow more Vermonters to participate.

Individuals enrolled in this Long-Term Care Demonstration Waiver program will include all elderly persons (age 65 years and older) and adults with physical disabilities aged 18 years and older, who have been identified as needing long-term care services and who meet the Medicaid financial eligibility criteria under the waiver.

[6] $2,000 for individuals electing nursing facility or other residential level of care; $10,000 for individuals electing home-based care.
[7] Ibid 6
[8] Ibid 6
[9] If the Demonstration enrollee also meets the eligibility criteria for the Community Medicaid Program, she/he will also be eligible for all State Plan Medicaid services.
[10] All enrollees will receive case management services.

No one under age 18 years will be enrolled in this program, but physically disabled children may be transitioned in from other programs serving children in the State of Vermont upon reaching adulthood. Individuals under age 18 will continue to be eligible for appropriate State Plan services.

Persons eligible for Medicaid and receiving long-term care services on the start date of this waiver will become enrolled in the Demonstration, including any recipients enrolled in existing Aged and Disabled 1915(c) waiver programs, which will be subsumed by the Section 1115 waiver. The result is to essentially "grandfather" in the population currently served in nursing facilities or through the Aged and Disabled 1915(c) waivers. Individuals in other 1915 (c) waivers operated by the State are not included in this Demonstration.

Individuals screened out through the PASARR will not be enrolled in the Demonstration, nor will PACE enrollees. Vermont has also submitted a proposal to CMS for the "Vermont Independence Project - VIP", which asks for Medicare reimbursement for case management services to assist individuals to manage their chronic disease. If this program is ultimately approved, the Medicare funds associated with case management services for the approved population will be rolled into this waiver.

Individuals residing in nursing facilities on a permanent basis, and whose assessment indicates that nursing facility care is the only safe and appropriate long-term care alternative, will be enrolled in the Demonstration. Individuals in this population will continue to be evaluated using the MDS unless their status changes and discharge from the nursing home is determined to be feasible. At that time they will be reassessed using the Independent Living Assessment.

New applicants will have a clinical assessment to determine potential eligibility for the Demonstration and the appropriate category of need – Highest, High or Moderate. They will also be screened in terms of financial eligibility. If the applicant meets the clinical criteria for the Highest Need group and, based on self-declared income and resource information, appears to meet the financial criteria, she/he will be presumptively enrolled so that services can begin immediately. The Department of Prevention, Assistance, Transition and Health Access (PATH) will make the financial eligibility determinations for all Demonstration enrollees. If the

presumptive eligibility process proves successful, it will be expanded to include individuals entering the High Needs group as well.

Once enrolled in the Demonstration, individuals must select a case management agency (either a regional home health agency or an Area Agency on Aging). All case managers must be certified by DA&D. There are extensive requirements with respect to education and/or experience. These are detailed later in the proposal. These requirements are identical to those approved by CMS in Vermont's current 1915 (c) waiver. The case manager will be responsible for the development, monitoring and updating of the enrollee's comprehensive care plan. The case manager will work collaboratively with the Enrollee and/or his/her designee on the development of the care plan. This collaborative effort can include spouses and other family members, guardians, friends and supportive caregivers.

Any Medicaid-eligible applicant who is denied enrollment in the Demonstration may appeal that denial according to existing Medicaid appeal procedures.

Consumers may enter appeals on clinical determinations (whether or not an individual is eligible or ineligible and also decisions about level of clinical need, i.e. appropriate LTC Program group), determination of financial eligibility, services authorized in the Plan of Care and how the person was evaluated in the prioritization process used for individuals waiting for services in the High and Moderate groups.

Chapter 3: Covered Services and Delivery Model in the Demonstration

Under the Demonstration there will be two types of services – Core and Optional. Core services will be available at all times, based on clinical needs, to Demonstration enrollees in the Highest Need group. Core services will also be available to the High and Moderate Need groups to the extent funding is available. Optional Services will be added to the Demonstration for all groups as funding becomes available.

Scope of Covered Services

Demonstration enrollees will be eligible to receive all covered long-term care services through this waiver program. Medicaid Sate Plan services will be provided as they are today. Services will be covered, based on their inclusion in an approved comprehensive care plan, at the level called for in that plan. The following is a description of the core services that may be included in a comprehensive care plan, based on the needs of the individual enrollee:

Core Services

Personal Care Services – There are two types of Personal Care Service providers; both types of providers render assistance with Activities of Daily Living (ADLs) like eating, dressing, walking, transferring, toileting and bathing. Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning, and shopping assistance may also be provided. Services may be provided by regional home health agencies or by attendants hired, trained, and supervised by qualified consumers or surrogates. This option is currently available under DA&D's 1915(c) Waiver. In some cases, these services are also currently being provided by relative caregivers, with the exception of spouses and individuals under the age of 18. This Demonstration will expand the use of relative caregivers on a compensated basis to include personal care services provided by a spouse. The State will make the determination as to whether the spouse is able to provide the personal care services included in the enrollee's care plan and is also the best provider to do so. DA&D will develop screening criteria, which will be used to evaluate requests for spousal caregiver services on a compensated basis. DA&D has administered an Attendant Services Program that uses this method of care delivery for more than 20 years.

Respite Care – Respite care may be provided in home settings, adult day centers, residential care homes or in nursing facilities to relieve primary caregivers.

Companion Services – This includes non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise with tasks such as meal preparation, laundry, and shopping, but these tasks are not performed as a discrete service. This service does not entail hands-on personal care. Companions may perform light housekeeping tasks, which are incidental to the care and supervision of the individual. Individuals providing this service must be high school graduates or the equivalent, 18 years of age or older and have training and skills that are specific and adequate to meet the needs of the individual participant. These qualifications are identical to those that were approved by CMS for Vermont's current 1915(c) waiver.

Adult Day Services – These are community-based non-residential services designed to assist impaired or isolated adults to remain as active in their communities as possible, maximizing their level of health and independence and ensuring the optimal functioning of the participant. Services include a range of health and social services for participants and provide respite for primary caregivers. Services are furnished for a specified number of hours per day on a regularly scheduled basis, for one or more days per week.

Personal Emergency Response Systems – These include electronic devices, which enable individuals at high risk to secure help in an emergency.

Assistive Devices and Home Modifications – Assistive Devices are any items used to increase, maintain or improve functional capabilities and independence in performing ADLs or IADLs. Home modifications include any physical adaptations to the home which are necessary to ensure health and welfare of the individual and which maintain, increase or improve functional capabilities and independence. This may include ramps, door widening, grab-bars and modification of bathroom facilities, etc., but not repairs, maintenance or new construction. Physical adaptations included in the enrollees comprehensive care plan are reimbursable up to $750 per calendar year. The State is reevaluating the per person amount allowed for this benefit.

Also included are electronic monitoring or tracking devices, which are necessary to ensure the health, welfare and safety of individuals with moderate to severe dementia or comparable cognitive impairment.

Nursing Facility Services – Care in a licensed nursing facility.

Enhanced Residential Care Home/Assisted Living Residences Services – A bundled package of services provided by an approved Level III Residential Care Home (RCH) or Assisted Living Residence (ALR). In addition to services provided to all RCH/ALR residents, these residential settings also provide a Registered Nurse on-site for a minimum of one hour/week per waiver participant, and an average of two hours of personal care services per waiver participant per day. Daily social and recreational activity opportunities are also provided.

Case Management Services – This includes assisting individuals in gaining access to needed waiver and other State Plan services as well as needed medical, social, educational and other services regardless of the funding source. The case manager is responsible for the ongoing monitoring of the provision of services included in the comprehensive care plan. The case manager performs necessary assessments and reassessments of the individual's needs and reviews plans of care at least annually or more often if needed to respond to changes in conditions or circumstances.

Homemaker Services – These include assistance with house cleaning, food preparation and clean up and shopping for individuals who do not otherwise require personal care services.

Optional Services

The following optional services will be added to the Demonstration as funding becomes available, subject to overall budget neutrality limitations:

Home Delivered Meals – This includes the provision of a meal(s) to the enrollee's residence, with each meal meeting 1/3 of the full daily nutritional regimen.

Other Living Arrangements – This includes support for alternative living arrangements such as activities in residential care or assisted living residences, and other appropriate supports for home sharing, Housing and Supportive Services (HASS) and adult foster family care.

Bed Hold/"Leave" Days – This includes payment for days (up to 10 days per episode) when the enrollee is away from the enhanced residential care home due to an acute inpatient admission.

Covered Service Limitations

The scope and quantity of services to be provided to an individual under the Demonstration will be clearly delineated in the enrollee's comprehensive care plan. Only those services included in the care plan are reimbursable by Medicaid under the Demonstration. "Off-plan" services are the financial responsibility of the enrollee, if not funded by another payment source.

Enrollees may appeal any denial of, or reduction in, services in the comprehensive care plan following the existing Medicaid appeal procedures.

Approved Medicaid providers provide all long-term care services included in an enrollee's care plan. Services are reimbursed on a fee-for-service basis, utilizing fee schedules approved by DA&D and the Office of Vermont Health Access (OVHA), the Medicaid Division of PATH. Regional home health agencies directly provide or arrange for the provision of many of the services included in the care plans. The five Area Agencies on Aging also provide waiver case management services and arrange for services provided in the care plans.

Vermont has chosen not to include the following Medicaid State Plan services in the 1115 Demonstration Waiver: (1) home health services including RN, physical therapy, occupational therapy, speech therapy, Licensed Nursing Assistant services, and social work; (2) Day Health Rehabilitative Services (DHRS); and (3) Assistive Community Care Services (ACCS). These services are targeted to individuals with more acute care and short-term rehabilitative needs.

DHRS services are delivered at adult day centers and are designed to provide rehabilitative services to frail elders and younger adults with physical disabilities.

Assistive Community Care Services are delivered in Level III licensed residential care homes and assisted living residences. The payment mechanism is complex and did not lend itself to inclusion in the Demonstration.

Vermont also intends to continue providing Licensed Nursing Assistant services outside of the waiver. These LNA services have historically been considered similar to Medicare LNA services, and are intermittent skilled services related to sub-acute and rehabilitative care, not on-going personal care.

Service Delivery and Financing Model

Medicaid approved and contracted fee-for-service providers and individuals under the consumer/surrogate directed options provide services included in an enrollee's comprehensive care plan. That system will remain in effect with this program. Claims will be submitted and reimbursed by the State's Fiscal Intermediary (EDS) in accordance with requirements and fee schedules in effect for the program. Individual providers or groups of providers will not be capitated or at-risk financially for the cost of care for any individual enrollee or group of enrollees.

In Vermont, many of the long-term care services will be provided by 12 regional home health agencies. Each home health agency serves a defined geographic region on a non-competitive basis. This model has been in place in Vermont for many years and has been shown to work best in an environment that is largely rural, and not conducive to competitively driven profit centers.

Other services will be provided by community-based entities such as small residential care homes and assisted living residences, Area Agencies on Aging, meals-on-wheels programs, Durable Medical Equipment vendors, home adaptation contractors, adult day centers, and individual attendants hired and supervised by Demonstration enrollees.

Nursing facilities will continue to be an important component of the service delivery system. Vermont's nursing facilities will provide institutional long-term care services to many Demonstration enrollees who choose and are eligible for this level of care. These facilities will continue to be reimbursed on a per diem basis at rates established by Division of Rate Setting.

Oversight, Monitoring and Reporting on Comprehensive Care Plans

In Vermont the regional home health agencies serve a dual role. First, these entities provide case management services and conduct updates and modifications to care plans. Second, they provide direct care services. To counter any bias in care plan development by organizations also charged with providing the services listed on the care plans, DA&D maintains a robust oversight, monitoring, and reporting function.

DA&D tracks the content of all care plans using its DAILCare database system. This system enables the department to compare and contrast the care plans developed by different agencies across like populations. It can examine differences between plans developed by area agencies on aging (which do not provide direct care services) and those developed by the home health agencies. The system also permits the department to closely monitor the quantity of services provided on a per enrollee and aggregate basis for each regional home health agency.

DA&D staff will review and approve all changes to plans of care. Where there are indications that the content of care plans of one or more agencies vary significantly from those of peer agencies serving similar populations, DA&D staff will evaluate the differences and determine if agencies are inappropriately ordering more or fewer services than appear necessary.

Additionally, DA&D has an ongoing monitoring and auditing function as a part of its utilization management program. DA&D UM staff will conduct site visits and review a sample of care plans quarterly. A uniform review tool will be used and results summarized and reported to each agency. Aggregate results will also be distributed to each home health agency and Area Agency on Aging.

As a part of its Quality Monitoring and Management (QMM) Program, DA&D clinical oversight staff review care plans to ensure that services on the plan are appropriate, both in scope and volume, relative to the identified needs of the individual enrollees. A random sample of ten percent of the cases from each of the 13 Waiver Team areas (with a minimum of five cases) will be reviewed annually. DA&D will use these findings and results as a part of its overall quality improvement activities. DA&D's proposed QMM program is further described in the next chapter.

Chapter 4: Quality Monitoring and Management Program

The Department of Aging and Disabilities will put in place a multi-faceted Quality Monitoring and Management (QMM) Program for the proposed Demonstration. The QMM program is reviewed in this Chapter and will be presented in more detail in the Operational Protocol for the Demonstration that will be subsequently submitted to CMS. The program is designed to ensure the highest possible level of quality of care and enrollee satisfaction with the long-term services provided under this Demonstration.

Consumer Satisfaction Survey

DA&D conducts an annual consumer satisfaction survey. This survey is based on a sample of recipients of home- and community-based care in the 1915(c) waivers and Attendant Services, Homemaker and Adult Day Programs. DA&D will continue to administer this survey under the Demonstration. To date survey results show high levels of consumer satisfaction with the care received. While it is acknowledged that consumer satisfaction alone does not necessarily ensure that the care was of high quality, it is an important indicator. A copy of the survey tool and the Executive Summary of the most recent completed survey are attached as Appendices F and G.

Review and Approval of all Plans of Care and Certification of Case Managers

The staff of the Department of Aging and Disabilities will review and approve all plans of care for Demonstration enrollees and any subsequent changes to those plans. This will ensure consistent approaches to care plan development and the allocation of resources. Additionally, all participants in the demonstration will have a designated case manager. The case managers must have a face-to-face visit with their assigned enrollees at least once a month and more frequently if necessary. Case managers are professionals who are certified by the State after the receipt of training and the passage of a comprehensive examination. Case managers who have been approved for certification must participate in a minimum of 20 hours of professional development education or training annually to maintain certification. Certification remains in effect unless revoked due to clear evidence that quality case management services, consistent with the DA&D Case Management Standards, are not being provided and/or professional

development and training has not been maintained. Where the Department has reason to believe that a case manager is not providing quality services, several actions occur. First DA&D will contact the agency case management supervisor and executive director to discuss the concerns and will proceed with an investigation. Second, the agency will evaluate the case manager's performance following DA&D written procedures. Based on the outcome of the agency's investigation, DA&D will make a determination regarding continued certification of the case manager.

When DA&D determines that it is necessary to revoke the certification of a case manager, that individual is prohibited from providing case management services unless the Commissioner grants him/her a provisional certification. A request for provisional certification must be submitted in writing within 30 days of the receipt of notification to revoke certification.

Tracking of Services Actually Provided

DA&D also monitors the quantity of services provided to enrollees versus those listed on the care plan. This ensures that the oversight agency knows what portion of the services included on the care plan were actually provided. For a variety of reasons, it is unlikely that 100 percent of the services listed would be provided, but a significant proportion should be delivered. In instances where a low proportion is observed by the State, DA&D staff will follow-up with the responsible agency to determine the reasons associated with the lack of service provision. A system for electronically tracking and trending this information for the Demonstration enrollees is being developed.

Local Waiver Teams

Under the Demonstration, as with the Vermont's current Home- and Community-Based Services waiver programs, local Waiver Teams will continue to provide significant oversight of the program. There are thirteen Waiver Teams throughout the State. These teams are comprised of representatives from the regional home health agencies, Area Agencies on Aging, adult day centers, local PATH offices, hospital discharge planners/social workers, residential care homes, assisted living residences and nursing facility social workers. Other providers such as the local

community mental health centers join the teams as needed. The teams meet monthly and review all active cases. Cases that involve outstanding issues are thoroughly discussed and alternative solutions or care approaches are reviewed. Under the demonstration, DA&D staff will facilitate the Waiver Teams, and provide technical assistance and updates about any changes in policies and procedures.

Oversight of Home Health Agencies/Residential Care Homes/Assisted Living Residences/Adult Day Centers

Much of the care provided to Demonstration enrollees will be provided by home health agencies around the state. These agencies are subject to state and federal regulations and are regularly surveyed by the DA&D Division of Licensing and Protection. These inspections include a review of the quality assurance and quality management activities and functions of the agency. DA&D also provides direct oversight of the residential care homes/assisted living residences in the State through its licensing and surveying responsibilities.

DA&D certifies all Adult Day Centers that receive state and/or federal funds as meeting the state standards. In addition, DA&D makes site certification visits to each Adult Day Center on at least an annual basis.

Checks and Balances in the Provider System

Many Demonstration enrollees receive services from multiple providers, including home health agencies, Area Agencies on Aging, adult day centers, respite service providers, transportation providers, and individual attendants. The involvement of multiple provider organizations helps to ensure a series of checks and balances in the system because all of these providers are mandated by law to report any actual or suspected abuse, neglect or exploitation. It also works to ensure that at least one provider will pick up on a situation that may be a precursor to future problems for the enrollee.

Other Quality Monitoring Activities

DA&D also conducts a variety of other monitoring activities to ensure quality of care. These include monitoring of grievances and appeals, nursing facility admission and re-admission rates to acute or long-term care facilities for Demonstration enrollees, DA&D interviews with consumers and changes in the functional status of enrollees based on their need for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

The expansion of the Long-Term Care Ombudsman program to include home-based care will also add an important new element to monitoring efforts. Additional monitoring activities are performed through the complaint line staffed by the DA&D Division of Licensing and Protection and through investigations by Adult Protective Service investigators.

All of the initiatives and activities described in this chapter are undertaken in an effort to ensure that Demonstration enrollees are receiving the right services at the right level at the right time, and that those services are of the highest level of quality possible. Collectively DA&D's approach to identifying and addressing shortcomings revealed by its monitoring activities should result in continuous quality improvement in the long-term care system overall and for individual enrollees.

Chapter 5 Caseload and Cost Estimates

Overview

This chapter provides caseload and cost estimates for the Vermont long-term care population, under both the existing system and the proposed waiver program. The proposed 1115 waiver will cover long-term care services only; no acute services or dollars will be included.

The 1115 waiver estimates are provided using a template developed by CMS for the Pharmacy Plus demonstration initiative. This is an appropriate template for the Vermont Long-Term Care Plan because, as with Pharmacy Plus, Vermont's demonstration will use an aggregate, rather than per capita, budget neutrality test.

The remainder of this chapter provides supporting narrative for the caseload and cost exhibits produced using the CMS template. The CMS-formatted exhibits are contained at the end of the chapter (the original Excel files are also being submitted under separate cover). For reader ease, portions of the exhibits are reproduced in summary form in the body of the text. As both the exhibits and tables show, the Vermont Long-Term Care Plan is projected to cost no more than the existing program, even while expanding eligibility to frail elderly and physically disabled Vermonters currently receiving no services[9].

Data Sources

The historical data presented in this chapter was extracted from Vermont's eligibility and claims payment systems and previously documented on the State's CMS-64 reports. The demographic and medical inflation trends applied to the historical data are an extrapolation of historical trends, with some adjustments to caseload based on expected growth rates among the elderly and adult disabled populations in Vermont, as described further below.

[9] The expenditure, and associated eligibility expansion projections in this chapter assume sufficient State appropriations to secure the maximum available federal matching funds. The size of any future expansion will ultimately depend on the actual dollars appropriated.

Historical and Projected Caseload under the Existing System

Historical Caseload

The portion of the existing Vermont Medicaid population to be subsumed under the 1115 waiver consists of persons ages 18 and older who are residents of a nursing facility or enrolled into either the 1915(c) Home- and Community-Based Services (HCBS) waiver or Enhanced Residential Care (HCBS-ERC) waiver. All long-term care services for these three groups are currently reimbursed on a fee-for-service basis and will continue to be so under the waiver. Exhibit 5-A at the end of the chapter presents five years of detailed historical caseload data, starting with State Fiscal Year 1998 and running through State Fiscal Year 2002. All information is reported in terms of average caseloads and total eligible months. Table 5-1 below presents the same data in summary form.

5-1 Historical Long-Term Care Caseloads by Setting

Medicaid LTC Population by Placement	State Fiscal Year					Pct Change 1998 - 2002	
	1998	1999	2000	2001	2002	Average Annual	Total
Nursing Facility	2,366	2,349	2,287	2,156	2,180	-2.0%	-7.9%
HCBS	611	630	730	813	895	10.1%	46.5%
HCBS-ERC	90	90	91	132	151	13.8%	67.8%
Total	3,067	3,069	3,108	3,101	3,226	1.3%	5.2%

As the above table reflects, nursing facility caseload has been gradually declining in Vermont for many years, the result of existing State 1915(c) waivers designed to offer home- and community-based service options to persons in need of long-term care. During the period 1998-2002, total nursing facility eligible months fell by an average of two percent each year, or about eight percent for the entire period. In 1998, the average daily Medicaid census in Vermont's nursing facilities was 2,366; in 2002 it was 2,180.

Over these same five years, HCBS waiver member months grew at an annual rate in excess of ten percent, or more than 46 percent overall. Average enrollment increased from 611 in 1998 to

895 in 2002. HCBS-ERC member months followed a similar path, increasing by nearly 14 percent per year, or 68 percent overall. Average enrollment in the HCBS-ERC waiver grew from 90 to 151.

Long-term care caseloads across all three settings grew at an average annual rate of 1.3 percent during the five-year historical period. This rate of increase is expected to accelerate in coming years, for the reasons discussed below.

Projected Caseload

Historical caseload trends are an important component of projecting future caseload, but must be considered in the context of broader demographic trends. Two key determiners of future long-term care needs in Vermont (regardless of the system in place) will be the growth of the elderly population and changes in disability rates among adults, both those under age 65 and those 65 and older.

To more precisely understand the State's future long-term care needs, the Vermont Department of Aging and Disabilities in 2002 conducted a study of demographic trends for the period 2000 – 2010 in conjunction with the Lewin Group and the University of Massachusetts Institute for Social and Economic Research. Findings from the study were issued in May of this year[10] and are summarized below.

The researchers relied on data from the 2000 Census and from the Current Population Survey to establish a population baseline for 2000 and projections through 2010. Disability trend rates for persons under age 65 were derived from Social Security Administration growth assumptions for

[10] The full report entitled, "Shaping the Future of Long-Term Care – 2000 to 2010" is included as Appendix H to this application.

the number of workers receiving disability insurance benefits. Disability trend rates for persons age 65 and older were derived from Kenneth Manton's recent analysis of the 1999 National Long-Term Care Survey[11].

According to the study, Vermont's population as a whole is projected to increase eight percent from 2000 to 2010, while the State's elderly population (age 65 and older) is projected to grow by 18 percent and the age 85 and older cohort by 27 percent.

Table 5-2 below presents ten-year population trends, by age cohort, for the Vermont population. (Note that percentage trends are for the start of the waiver period through 2010).

5-2 Vermont Population Trends

Age	2000		2005	2006	2007	2008	2009	2010	Pct Change 2005 - 10 Average Annual	Pct Change 2005 - 10 Total
Under 18	147,523		143,274	141,156	139,038	136,919	134,801	132,683	-1.5%	-7.4%
18 to 39	180,259		172,520	172,173	171,825	171,478	171,130	170,783	-0.2%	-1.0%
40 to 64	203,265		239,179	244,235	249,291	254,347	259,403	264,459	2.1%	10.6%
65 to 74	40,683		41,862	43,008	44,154	45,300	46,446	47,592	2.7%	13.7%
75 to 84	26,831		29,757	30,052	30,347	30,641	30,936	31,231	1.0%	5.0%
85+	9,996		11,283	11,568	11,853	12,138	12,423	12,708	2.5%	12.6%
TOTAL	608,557		637,875	642,191	646,507	650,824	655,140	659,456	0.7%	3.4%

The rapid growth in the number of aged Vermonters will be slightly offset by disability trends among the elderly. Recent national studies show a small drop off in the disability rate for persons age 65 and older, due to improvements in health, nutrition and medical treatments.[12] While these improvements may be less evident in the lower income population, the State estimates that the disability rate among elderly Vermonters will decline by about one percent each year through 2010.

There is an opposite trend line when looking at the population under age 65. Relying on national data, the State projects that the prevalence of disability among younger adults will climb by

[11] Manton, Kenneth F and Gu, XiLiang, Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population above Age 65 from 1982 – 1999. *Proceedings of the National Academy of Sciences*, Vol. 98, No. 11, 2001.

[12] Redfoot, Donald L and Pandya, Sheel M, Before the Boom: Trends in Long-Term Supportive Services for Older Americans with Disabilities. *AARP Public Policy Institute Issue Paper*, No 2002-15 (October 2002).

approximately three percent per year, primarily because medical advances are permitting more children with disabilities to survive into adulthood, and allowing adults with disabilities to live longer.

Taking all of these trends into consideration, the State projects that the number of adult Vermonters currently living at home or in the community who will require long-term care during the demonstration years will increase at an annual rate of 2.9 percent each year through 2010[13]. The number of low income Vermonters[14] requiring such care will grow at an even faster annual rate of 3.6 percent (see Table 5-3 below).

This acceleration in the rate of increase from the historical pace is consistent with the expected rapid growth in the number of elderly Vermonters over the next five years, particularly the age 85 and older cohort.

5-3 Projected New Long-Term Care Need

	Calendar Year							Pct Change 2005 - 10	
	2000	2005	2006	2007	2008	2009	2010	Average Annual	Total
All Persons	*3,424*	4,538	4,670	4,801	4,867	5,064	5,196	2.9%	14.5%
Low Income	*1,558*	1,967	2,038	2,108	2,144	2,249	2,320	3.6%	17.9%

This reasonableness of this upward trend is also supported by the fact that, even with steady growth in HCBS enrollment during the past five years, Vermont has had a small but persistent waiting list of persons found eligible for the 1915(c) HCBS waiver but for whom no slots were available.

Historical and Projected Cost under the Existing System

Historical Cost

Like virtually every other state, Vermont has experienced a steady increase in per eligible costs for long-term care services over the past five years. Exhibit 5-A contains expenditure data for

[13] The State defines this group as persons requiring assistance with two or more ADL's, excluding individuals with mental retardation or developmental disabilities. This is consistent with existing eligibility criteria for the 1915(c) waivers.

[14] Defined as persons with incomes below 175 percent of FPL

the period 1998 – 2002, along with the caseload data previously discussed – both per eligible and aggregate.

Table 5-4 below presents summary information on average annual per eligible expenditures, by setting, during the five-year historical period. As it shows, the HCBS waiver in SFY 2002 was only 52 percent as costly as nursing facility placements, while the HCBS-ERC waiver was only 28 percent as costly. Although per capita expenditures have been increasing at a more rapid pace in the two 1915(c) programs than for nursing facilities, they remain far less costly on a per eligible basis.

5-4 Historical Long-Term Care Expenditures by Setting (Annual per Eligible)

Medicaid LTC Population by Placement	State Fiscal Year					Pct Change 1998 - 2002		HCBS as Pct of NF-2002
	1998	1999	2000	2001	2002	Average Annual	Total	
Nursing Facility	$ 31,818	$ 32,238	$ 35,230	$ 37,341	$ 41,936	7.2%	31.8%	
HCBS	10,923	13,068	16,211	16,597	21,584	18.6%	97.6%	51.5%
HCBS-ERC	6,550	8,575	11,268	9,242	11,724	15.7%	79.0%	28.0%
Weighted Avg	$ 28,226	$ 28,812	$ 31,401	$ 32,488	$ 36,586	7.8%	29.6%	

In terms of aggregate spending, the Vermont long-term care program has grown by $30 million (state and federal) over the past five years, from less than $83 million (state and federal) in SFY 1998 to nearly $113 million in SFY 2002. Table 5-5 below presents summary data on aggregate expenditures.

5-5 Historical Long-Term Care Expenditures by Setting (Aggregate in 000's)

Medicaid LTC Population by Placement	State Fiscal Year (000's)					Five Year Total	Pct Change 1998 - 2002	
	1998	1999	2000	2001	2002		Average Annual	Total
Nursing Facility	$ 75,281	$ 75,727	$ 80,570	$ 80,508	$ 91,421	$ 403,507	5.0%	436.0%
HCBS	6,674	8,233	11,834	13,493	19,318	59,552	30.4%	792.3%
HCBS-ERC	589	772	1,025	1,220	1,771	5,377	31.6%	812.9%
Total	$ 82,544	$ 84,732	$ 93,429	$ 95,221	$ 112,510	$ 468,436	8.2%	467.5%

Projected Aggregate Costs Absent the Waiver

The appropriate trend factor for projecting aggregate costs is one that takes into account both caseload growth and medical inflation.

With respect to caseload growth, Vermont is projecting a 3.6 percent annual rate of increase across all settings, consistent with the Lewin Group/University of Massachusetts study findings. As shown in Table 5-6 below, the actual rate within the three program types will continue to differ, although the gap is expected to close slightly.

Absent the 1115 waiver, the State projects nursing facility days will stop declining and instead will grow at a modest rate of one percent per year as the number of frail and adults with disabilities continues to rise. The State projects that the two 1915(c) waiver programs will also continue to grow, but at a slightly reduced pace than that seen during the past five years. Without an 1115 waiver, HCBS waiver days are projected to increase at an annual rate of eight percent, down from ten percent; HCBS-ERC days are projected to increase at an annual rate of 11 percent, down from 13.8 percent.

With respect to cost, Vermont sees nothing in the historical data or broader national trends to suggest that the current medical inflation rate is likely to subside any time soon. The State therefore is projecting that the historical trend rates for each setting during the past five years will continue for the five-year demonstration period.

5-6 Proposed Caseload and Cost Trend Factors Absent the Waiver

	Annual Caseload Change		Annual Cost Change	
Trend Period	Historical	Waiver Period	Historical	Waiver Period
Nursing Facility	-2.0%	1.0%	7.2%	7.2%
HCBS	10.1%	8.0%	18.6%	18.6%
HCBS-ERC	13.8%	11.0%	15.7%	15.7%

Exhibit 5-B presents detailed annual and five-year expenditure projections under the current system, using the above "waiver period" trend factors. Table 5-7 below shows the same information in summary form.

5-7 Projected LTC Expenditures Absent the Waiver (Aggregate in 000's)

	State Fiscal Year (000's)					
	2005	2006	2007	2008	2009	Five Year Total
Total LTC Expenditures	$ 160,176	$ 182,139	$ 208,378	$ 239,937	$ 278,141	$ 1,068,771

Projected Cost under the Waiver

As described in detail elsewhere in the proposal, Vermont intends to restructure its long-term care system so that, in the future, a larger portion of the population found eligible for long-term care may choose to be served in less costly home- and community-based settings rather than nursing facilities. The State is conservatively projecting that about nine percent of the adult Medicaid population that would have moved into nursing facilities during the demonstration years will instead elect to be served at home or in another community-based setting.

As shown in detail in Exhibits 5-C/5-D, and in summary form in Table 5-8, the State expects the shift toward greater use of home- and community-based services will reduce expenditures over the five years of the waiver, by approximately $61 million (State and federal) versus what they would have been absent the waiver. Subject to appropriations from the Legislature, the State intends to use approximately 90 percent of the available $61 million to serve individuals enrolled in the High Need and Moderate Need groups of the 1115 waiver, with the remaining ten percent left available for contingencies (again subject to appropriation of State matching funds).

5-8 Projected LTC Expenditures under the Waiver (Aggregate in 000's)

Total LTC Expenditures	State Fiscal Year (000's) 2005	2006	2007	2008	2009	Five Year Total
Without Waiver	$ 160,176	$ 182,139	$ 208,378	$ 239,937	$ 278,141	$ 1,068,771
With Waiver - Existing	$ 150,906	$ 171,480	$ 196,165	$ 225,985	$ 262,246	$ 1,006,782
With Waiver - Expansion	$ 9,960	$ 10,558	$ 11,191	$ 11,863	$ 12,574	$ 56,146
Difference (Without - With)	$ (690)	$ 101	$ 1,022	$ 2,089	$ 3,321	$ 5,843

As demonstrated through these caseload and cost tables, Vermont is confident that it will be able to extend services to persons in need who currently receive no assistance, while producing savings for both the State and federal governments.

EXHIBIT 5-A

HISTORIC DATA: BASE YEAR (BY) AND 4 PRIOR YEARS FOR CURRENT LAW POPULATIONS

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	BY-4	BY-3	BY-2	BY-1	SFY2002	5-YEARS
TOTAL EXPENDITURES						
Nursing Facility Residents	$ 75,280,975	$ 75,726,707	$ 80,569,879	$ 80,508,083	$ 91,420,716	$ 403,506,360
Average Census	2,366	2,349	2,287	2,156	2,180	
COST PER ELIGIBLE	$ 31,818	$ 32,238	$ 35,230	$ 37,341	$ 41,936	
TREND RATES		**ANNUAL CHANGE**				**5-YEAR AVERAGE**
TOTAL EXPENDITURE		0.59%	6.40%	-0.08%	13.55%	4.98%
ELIGIBLE MEMBER MONTHS		-0.72%	-2.64%	-5.73%	1.11%	-2.03%
COST PER ELIGIBLE		1.32%	9.28%	5.99%	12.30%	7.15%
TOTAL EXPENDITURES						
HCBS	$ 6,673,912	$ 8,232,901	$ 11,833,772	$ 13,493,438	$ 19,317,629	$ 59,551,652
ELIGIBLE MEMBER MONTHS	611	630	730	813	895	
COST PER ELIGIBLE	$ 10,923	$ 13,068	$ 16,211	$ 16,597	$ 21,584	
TREND RATES		**ANNUAL CHANGE**				**5-YEAR AVERAGE**
TOTAL EXPENDITURE		23.36%	43.74%	14.02%	43.16%	30.43%
ELIGIBLE MEMBER MONTHS		3.11%	15.87%	11.37%	10.09%	10.01%
COST PER ELIGIBLE		19.64%	24.05%	2.38%	30.05%	18.56%
TOTAL EXPENDITURES						
HCBS-ERC	$ 589,483	$ 771,737	$ 1,025,352	$ 1,219,894	$ 1,770,393	$ 5,376,859
ELIGIBLE MEMBER MONTHS	90	90	91	132	151	
COST PER ELIGIBLE	$ 6,550	$ 8,575	$ 11,268	$ 9,242	$ 11,724	
TREND RATES		**ANNUAL CHANGE**				**5-YEAR AVERAGE**
TOTAL EXPENDITURE		30.92%	32.86%	18.97%	45.13%	31.64%
ELIGIBLE MEMBER MONTHS		0.00%	1.11%	45.05%	14.39%	13.81%
COST PER ELIGIBLE		30.92%	31.40%	-17.98%	26.87%	15.67%

EXHIBIT 5-B Annual and 5 –Year Expenditure Projections Under the Current System

MANDATORY POPULATIONS									
ELIGIBILITY GROUP	Historical	Estimated	MONTHS OF AGING	DEMONSTRATION YEARS (DY) SFY 05	SFY 06	SFY 07	SFY 08	SFY 09	TOTAL WOW
Nursing Facility Residents									
Eligible Member Months	-2.03%	1.00%	36	2,246	2,269	2,291	2,314	2,337	
Total Cost Per Eligible	7.15%	7.15%	36	$ 51,590	$ 55,279	$ 59,231	$ 63,466	$ 68,004	
Total Expenditure				$ 115,873,804	$ 125,400,369	$ 135,710,161	$ 146,867,571	$ 158,942,289	$ 682,794,194
HCBS									
Eligible Member Months	10.01%	8.00%	36	1,127	1,218	1,315	1,420	1,534	
Total Cost Per Eligible	18.56%	18.56%	36	$ 35,970	$ 42,647	$ 50,562	$ 59,946	$ 71,072	
Total Expenditure				$ 40,554,557	$ 51,928,001	$ 66,491,105	$ 85,138,403	$ 109,015,297	$ 353,127,363
HCBS-ERC									
Eligible Member Months	13.81%	11.00%	36	207	229	254	282	314	
Total Cost Per Eligible	15.67%	15.67%	36	$ 18,145	$ 20,988	$ 24,277	$ 28,081	$ 32,482	
Total Expenditure				$ 3,747,148	$ 4,811,102	$ 6,177,152	$ 7,931,073	$ 10,182,999	$ 32,849,473
Total Plan Expenditure				**$ 160,175,509**	**$ 182,139,472**	**$ 208,378,417**	**$ 239,937,047**	**$ 278,140,585**	**$ 1,068,771,030**

EXHIBIT 5-C DEMONSTRATION WITH WAIVER (*W/W*)
BUDGET PROJECTION

STATE PLAN POPULATIONS

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Nursing Facility Residents								
		eligibles entering HCBS rather than NF						
NF to HCBS members			180	193	206	220	234	
Eligible Members	1.00%	36	2,066	2,076	2,085	2,094	2,104	
Total Cost per Eligible	7.15%	36	51,590	55,279	59,231	63,466	68,004	
Total Expenditure			$ 106,603,900	$ 114,741,338	$ 123,496,246	$ 132,915,152	$ 143,048,060	$ 620,804,696
HCBS								
		eligibles entering HCBS rather than NF						
NF to HCBS members								
Eligible Members	8.00%	36	1,127	1,218	1,315	1,420	1,534	
Total Cost per Eligible	18.56%	36	35,970	42,647	50,562	59,946	71,072	
Total Expenditure			40554556.79	51928001.13	66491105.19	85138402.66	109015297.4	353127363.2
HCBS-ERC								
		eligibles entering HCBS rather than NF						
NF to HCBS members								
Eligible Members	11.00%	36	207	229	254	282	314	
Total Cost per Eligible	15.67%	36	18,145	20,988	24,277	28,081	32,482	
Total Expenditure			$ 3,747,148	$ 4,811,102	$ 6,177,152	$ 7,931,073	$ 10,182,999	$ 32,849,473
Total Plan Expenditure			**$ 150,905,605**	**$ 171,480,441**	**$ 196,164,503**	**$ 225,984,628**	**$ 262,246,356**	**$ 1,006,781,532**
Total New Expenditure			**$ 9,960,000**	**$ 10,557,600**	**$ 11,191,056**	**$ 11,862,519**	**$ 12,574,271**	**$ 56,145,446**
Total WW Expenditure			**$ 160,865,605**	**$ 182,038,041**	**$ 207,355,559**	**$ 237,847,148**	**$ 274,820,626**	**$ 1,062,926,978**
Total WOW Expenditure			**$ 160,175,509**	**$ 182,139,472**	**$ 208,378,417**	**$ 239,937,047**	**$ 278,140,585**	**$ 1,068,771,030**
SAVINGS			**$ (690,096)**	**$ 101,431**	**$ 1,022,858**	**$ 2,089,900**	**$ 3,319,958**	**$ 5,844,052**

EXPANSION POPULATIONS

ELIGIBILITY GROUP	ANTICIPATED FIGURES	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
High Needs									
			Enrollees	120	127	135	143	151	
Eligible Member Months	$ 1,440	6.00%		1,440	1,526	1,618	1,715	1,818	
Total Cost per Eligible	$ 5,500		0	$ 5,500	$ 5,500	$ 5,500	$ 5,500	$ 5,500	
Total Expenditure	$ 7,920,000			$ 7,920,000	$ 8,395,200	$ 8,898,912	$ 9,432,847	$ 9,998,818	$ 44,645,776
Moderate Needs									
			Enrollees	250	265	281	298	316	
Eligible Member Months	$ 3,000	6.00%		3,000	3,180	3,371	3,573	3,787	
Total Cost per Eligible	$ 680		0	$ 680	$ 680	$ 680	$ 680	$ 680	
Total Expenditure	$ 2,040,000			$ 2,040,000	$ 2,162,400	$ 2,292,144	$ 2,429,673	$ 2,575,453	$ 11,499,670
Total NEW Expenditure	$ 9,960,000			**$ 9,960,000**	**$ 10,557,600**	**$ 11,191,056**	**$ 11,862,519**	**$ 12,574,271**	**$ 56,145,446**

EXHIBIT 5-D

SUMMARY SHEET

5 Year Historical Trends Summary for Mcaid	cost	elig	pmpm
Pop 1 in state history	4.98%	-2.03%	7.15%
Pop 1 in wow		1.00%	7.15%
Pop 2 in history	30.43%	10.01%	18.56%
Pop 2 in wow		8.00%	18.56%
Pop 3 in history	30.92%	32.86%	18.97%
Pop 3 in wow		11.00%	15.67%

WITHOUT WAIVER BUDGET TOTAL	$ 1,068,771,030
WITH WAIVER SP TOTAL	$ 1,006,781,532
5 year Demo Population Costs	$ 56,145,446
SAVINGS	$ 5,844,052

ELIGIBLES ENTERING HCBS RATHER THAN NF	1	2	3	4	5	total or ave
Pop 1 WOW	2246	2,269	2,291	2,314	2,337	11,457
Pop 1 W/W	2066	2,076	2,085	2,094	2,104	10,425
MMs new HCBS	2,156	2,314	2,474	2,638	2,805	1,032
Indivs new HCBS	180	193	206	220	234	86
% change	8%	8%	9%	9%	10%	9%
Pop 2 WOW	1127	1218	1315	1420	1534	6614
Pop 2 W/W	1127	1218	1315	1420	1534	6614
MMs new HCBS	-	-	-	-	-	-
Indivs new HCBS	0%	0%	0%	0%	0%	0%
% change	0%	0%	0%	0%	0%	0%
Pop 3 WOW	207	229	254	282	314	1286
Pop 3 W/W	207	229	254	282	314	1286
MMs new HCBS	-	-	-	-	-	-
Indivs new HCBS	0%	0%	0%	0%	0%	0%
% change	0%	0%	0%	0%	0%	0%

Chapter 6: Research and Evaluation Plan

Vermont will conduct an evaluation of the Demonstration in cooperation with the Independent Evaluator selected by CMS. Vermont takes seriously the evaluation component of the Demonstration and is anxious to develop meaningful data and analyses that can guide the program as it evolves. Accordingly, DA&D intends to utilize the Evaluation process as a part of its Continuous Quality Improvement activities, taking the opportunities inherent in the process to garner substantial information on the effects and impact of the Demonstration on the lives of its participants and the long-term care system in general.

As a part of the evaluation, the Department of Aging and Disabilities will seek answers to the following questions regarding the effect of the project on the long-term care system and its participants.

Evaluation Questions and Methodologies

Question #1**:** Which functional, cognitive, and medical measures are the best predictors of individuals at risk for institutional placement in the medium term (twenty four months or less)?

Methodology: The State will collect functional, cognitive and clinical measures from assessment tools used in the program and track the institutional status of each Demonstration enrollee to identify any correlation between these measures and the timing of any subsequent admission to a nursing facility.

Question #2: Is it more cost effective for the overall long-term care program to furnish a comprehensive package of HCB services to individuals, based on their specific needs, than to operate a system where there is an institutional bias (the current system)? Does the Demonstration achieve lower costs overall than the system's historical costs? What are the per

enrollee per year costs (PEPY) under the Demonstration versus the historical per recipient per year costs?

Methodology: Vermont has extensive data on the cost of the current long-term care program on an aggregate and per recipient basis. Going forward under the Demonstration, costs will be closely tracked and compared to these historical benchmarks.

Question #3: If enrollee needs are adequately assessed and a care plan comprised of HCB services is implemented early enough, can the need for nursing facility care be significantly delayed or eliminated? Are there population characteristics that are accurate predictors of the degree of delay or elimination?

Methodology: Information collected during the Referral Intake and Preliminary Assessment Process, and the Evaluation of Individual Enrollee Clinical Needs and Social Supports will be analyzed to determine the degree to which early intervention impacts the likelihood of a subsequent nursing facility admission. These data will also be analyzed to ascertain if certain population characteristics (e.g., spouse living in the home, residing with adult children, living alone, etc.) appear correlated with higher or lower rates of nursing facility admission and the timeframes in which the admission occurs.

Question #4: Do pre- and post-implementation survey results indicate that enrollees are more satisfied under the Demonstration than was historically the case with the fee-for-service long-term care program? Are the results different for enrollees who were previously served in the 1915(c) waiver programs?

Methodology: The state will conduct pre- and post-implementation surveys to establish both a baseline (pre-implementation survey) and to collect comparable data post-implementation, at intervals to be determined. Pre-implementation surveys will be conducted with two distinct groups of recipients – those enrolled in one of the 1915(c) waivers and those receiving long-term care services outside of any HCBS waiver.

Question #5: Does the Demonstration impact the array and amount of services available in the community? Does this vary by the geographical region of the state? What are the pre- and post-Demonstration service inventories in each region of the State?

Methodology: The State will assemble a pre-implementation inventory based on DA&D's current information with respect to resources in the community. At the end of Year 3 of the Demonstration, the State will assemble a new inventory and compare changes by geographic region and type of service.

Question #6: What impact does the Demonstration have on nursing facility census in the State? What impact does the Demonstration have on nursing facility acuity levels?

Methodology: Nursing facility occupancy rates and acuity levels will be continuously monitored throughout the Demonstration.

Question #7: Do the educational programs expand the level of knowledge in the community with respect to long-term care resources, including Medicaid (based on pre- and post-implementation surveys)?

Methodology: The State will conduct written, telephone or focus group surveys before, and at one-year intervals after, implementation of the Demonstration to assess the impact of its educational programs.

Question #8: Does presumptive eligibility for the long-term care population "work", that is, are the vast majority of recipients ultimately found to meet the eligibility criteria when a comprehensive review is completed. What are the costs of the presumptively eligibility program?

Methodology: The State will track the reasons and costs for all enrollees found ineligible for the Demonstration, but who were receiving services temporarily as a presumptive eligible. The State will also track the total numbers of persons served as presumptive eligibles.

Conduct Surveys

The Evaluation Plan envisions a series of pre-implementation surveys to establish a baseline of recipient satisfaction with the current long-term care Medicaid program, including the existing HCBS waiver programs. A pre-implementation survey will also be conducted to determine the level of knowledge of Vermont residents with respect to the availability of long-term care services in the local communities and the rules and eligibility requirements for obtaining Medicaid coverage.

A region-by-region inventory of home- and community-based long-term care services and resources will also be taken. DA&D, in cooperation with OVHA, will establish baseline cost and utilization information for the existing Medicaid long-term care program consistent with the historical data provided in Chapter 5 – Caseload and Cost Estimates.

DA&D expects to conduct these surveys and inventories immediately upon approval of the waiver and before full implementation of the Demonstration program. DA&D will consult with the independent evaluator selected by CMS for this 1115 waiver on the design and execution of such surveys.

Chapter 7: Demonstration Administration

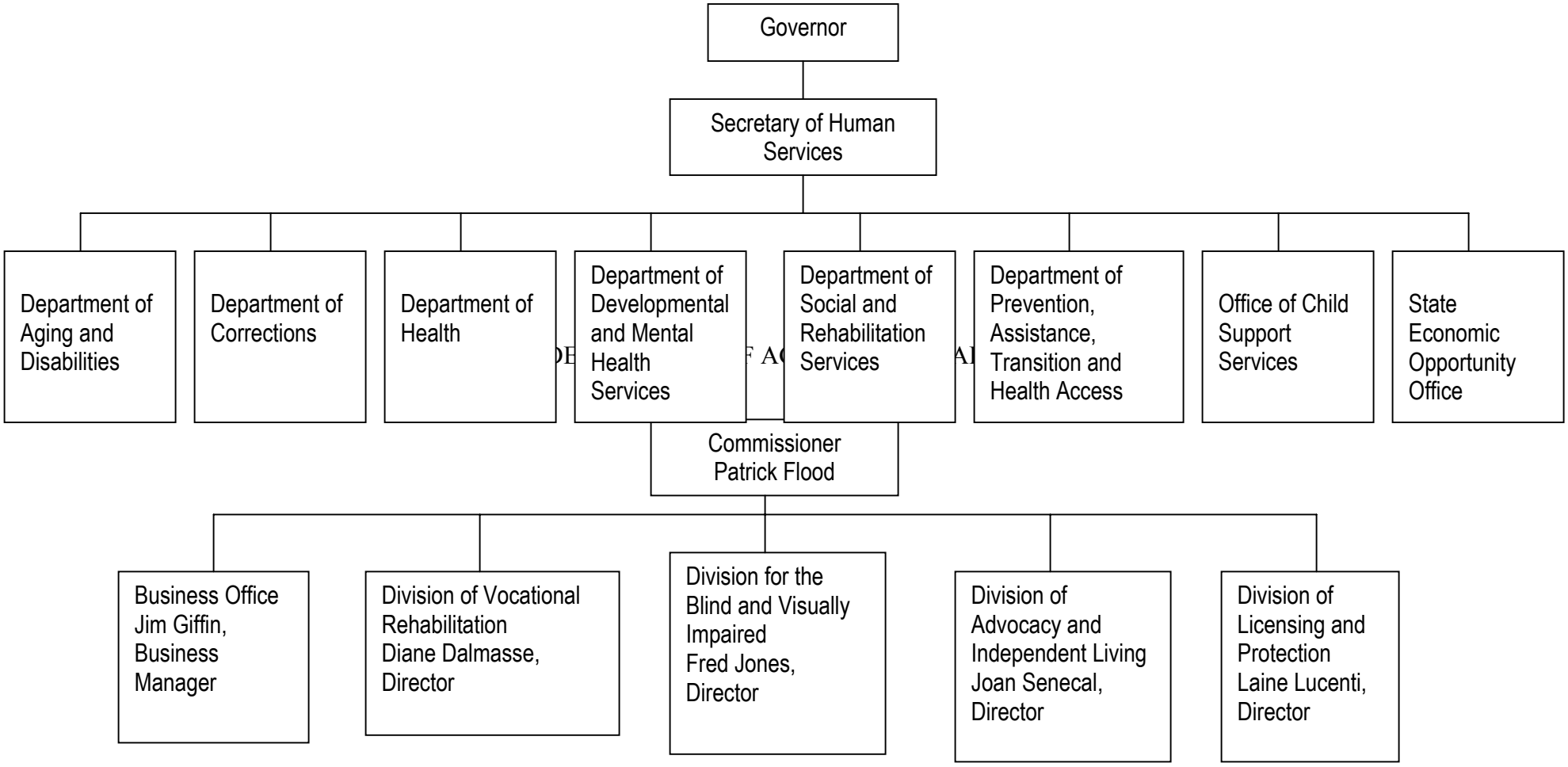
Overview of Organizational Change

The Demonstration will be administered by the Department of Aging and Disabilities (DA&D), within the Agency of Human Services for the State of Vermont. The Department's Commissioner, Patrick Flood, will serve as the Executive Officer for the Demonstration. Joan Senecal, Director, Division of Advocacy and Independent Living, will serve as the day-to-day Operational Director for the program.

DA&D will receive a global budget from the Agency of Human Services to conduct the Demonstration. That budget will be equal to the fee-for-service equivalent cost of the pre-waiver long-term care program. DA&D will re-organize its core business operations under the Demonstration to function as a managed long-term care plan. These functions are described in this Chapter. DA&D will meet the requirements of the 1997 Balanced Budget Act with respect to the operation of managed care programs

DA&D will maintain close-working relationships with other State agencies, departments and divisions affected by the Demonstration. This includes the various departments within the Agency of Human Services.

AGENCY OF HUMAN SERVICES ORGANIZATIONAL CHART

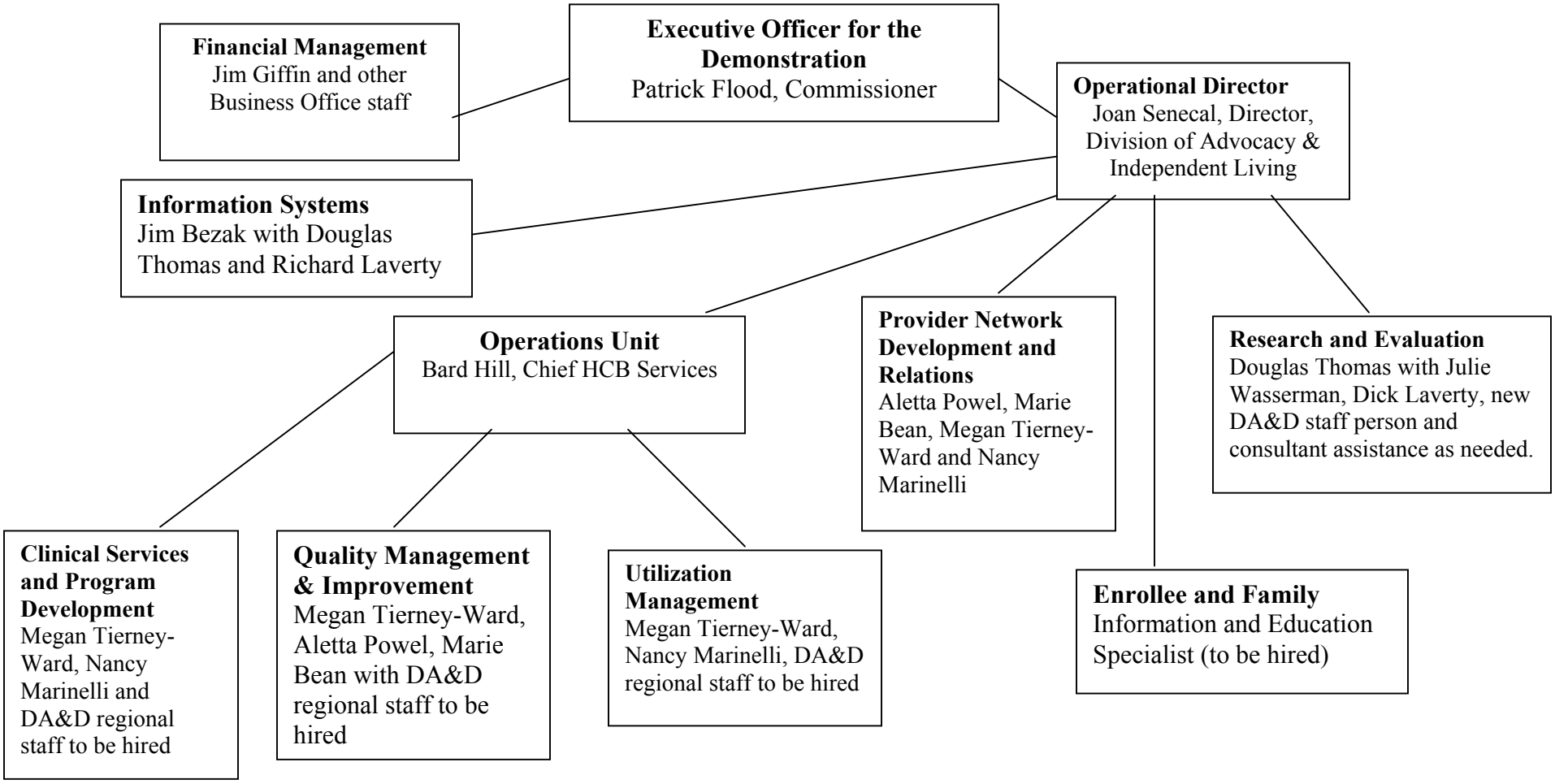


Proposed Demonstration Administration and Management

The Department has identified eight functional areas necessary to support its core business operations for the Demonstration. These units have responsibility for distinct operational processes necessary to administer the Demonstration.

- Clinical Services and Program Development
- Provider Network Development and Relations
- Quality Management and Improvement
- Research and Evaluation
- Enrollee and Family
- Utilization Management
- Financial Management
- Information Systems

1115 LONG-TERM CARE WAIVER
FUNCTIONAL ORGANIZATION CHART



• The DA&D Division of Licensing and Protection is the survey and certification agency for all nursing facilities, residential care/assisted living and home health agencies. DLP will work closely with the Quality Management and Improvement and Utilization Management Units.

The roles and responsibilities of each functional area are described in this Chapter. The functions in many respects mirror the operational units within most managed care organizations. This is appropriate given the functional role that DA&D is assuming under the Demonstration. The Department will operate as the managed long-term care plan for the State. Accordingly, it will have in place the necessary administrative and financial services to operate a long-term care managed care organization.

Description of the Operational Units

Clinical Services and Program Development

This Unit is responsible for the overall design of the Demonstration and the policies and procedures governing its implementation and operations. This includes policies related to benefit design, service coverage and delivery, the use of uniform assessment and evaluation tools, and care plan content. Clinical Services and Program Development staff are also responsible for designing and disseminating procedures with respect to emergency contingency plans for Demonstration enrollees.

Enrollee and Family Services

This Unit is responsible for Enrollee Outreach and Educational programs, Grievances and Appeals, and Enrollee Inquiry Response (done by the Medicaid Member Services Unit). The Unit maintains an Enrollee HelpLine where referrals for Intake and Preliminary Assessments can be made and individuals can obtain basic information about the Long-Term Care Demonstration program.

Provider Network Development and Relations

This Unit is responsible for network development and contracting with long-term care providers. Staff provide oversight of providers and identify and address shortfalls in the network. The Unit is also responsible for Provider Education and Provider Appeals. They respond to inquiries from physicians in the community with respect to eligibility for, and services provided under, the Demonstration.

Utilization Management

This Unit is responsible for all Utilization Review activities, including monitoring of care plan content and delivery of services. The UM staff will monitor the actual provision of care through claims analysis, and evaluate the medical necessity and appropriateness of care delivered to beneficiaries on a retrospective basis. UM staff will approve all nursing facility admissions and coordinate discharge planning activities with Certified Case Managers.

Quality Monitoring and Management

This Unit has ultimate responsibility for the quality of care and services provided under the Demonstration. The Unit conducts quality oversight of regional home health agencies and Area Agency on Aging Certified Case Managers. It also evaluates service providers to ensure that quality of care issues are identified and addressed. In conjunction with the UM staff, this Unit conducts audits and reviews of care plans and budgets.

Financial Management

This Unit has overall responsibility for ensuring that the Department functions within the global budget for the Demonstration. The Unit conducts financial analyses and provides financial projections of obligated but unincurred costs under approved comprehensive care plans. The

Unit provides periodic reports to the Executive Officer and Operational Director on the financial status of the Demonstration.

Research and Evaluation

This Unit is responsible for coordinating with the CMS-designated Independent Evaluator on the design and execution of the Evaluation Plan. The Unit conducts surveys and statistical analyses of data and information on the impact of the program in key evaluation areas. The staff test hypotheses with respect to outcomes under the Demonstration and reports program results to the Executive Officer and Operational Director.

Information Systems

This Unit is responsible for the systematic collection, processing and storage of all data and information on the Demonstration. It is also responsible for developing databases and automated solutions for capturing and analyzing the content of the comprehensive care plans and their associated budgets.

Chapter 8: Public Notice and Community Support

Public Notice and Feedback

Vermont routinely seeks public input when major changes are proposed for any part of the long-term care system. Because this application proposes a significant change from the long-held public policy that creates a bias toward institutional care, DA&D has taken a number of steps to ensure that interested parties are, and will continue to be, fully informed about the proposal and have ample opportunity to comment. In addition, DA&D will continue meeting with the various workgroups that are assisting with the many details that must be clarified prior to implementation.

First Stage of Public Notice and Input

Nine public meetings were held during June 2003. The meetings were convened by the ten community-based Long-Term Care Coalitions, which encompass the entire state. Over 400 people attended these meetings. The Coalitions used funds from Vermont's Real Choice System Change Grant to publicize and organize the meetings. The Commissioner of the Department of Aging and Disabilities and/or the Director of the Division of Advocacy and Independent Living gave an MS PowerPoint presentation on the purpose, program goals, concepts and next steps for the waiver application. Comments and suggestions were received at each meeting and then presented, by Coalition area, on the DA&D website.

At the end of each meeting, participants were invited to sign up for various work groups that would assist DA&D in developing policies and procedures to handle the myriad of implementation details. Approximately 150 individuals signed up for the work groups. These groups are: Eligibility; Navigating the System (developing operational protocols between DA&D staff and local agencies); Public Information and Education; Cash and Counseling Pilot; and Quality Assurance/Quality Improvement. Meetings of the Eligibility and Navigating the System groups were immediately held using Vermont Interactive Television (ITV). All ITV sites were

made available to encourage maximum participation. Work group meetings will continue through the fall and early winter.

The DA&D Commissioner also provided separate briefings to the Governor and his staff, the Legislative Health Access Oversight Committee and for the Chairs of the Senate and House Health and Welfare Committees. He also held several separate meetings with the executive directors of the home health agencies, Area Agencies on Aging and a meeting with the directors of the Adult Day Centers.

The Division Director held briefing with the Governor's Commission on Alzheimer's Disease and Related Disorders, the Medicaid Advisory Board and the Eligibility Committee for the Attendant Services Program.

Second Stage of Public Notice and Input

Over the summer, a draft proposal was developed, which incorporated many of the ideas gleaned from these meetings. The draft was circulated for comment in early September. Over 300 individuals received copies of the draft and were invited to submit their input. An ITV meeting, again using all the sites, was held to elicit more discussion about the proposal and to receive verbal comments. The organizations that received copies and provided written feedback, include: the Vermont Health Care Association (represents nursing facilities and many residential care homes); the Area Agencies on Aging; the Community of Vermont Elders; the State Health Care Ombudsman; the Disability Law Project, the State Long-Term Care Ombudsman; the Vermont Assembly of Home Health Agencies; the Vermont Association of Hospitals and Health Systems; the Vermont Coalition for Disability Rights; AARP; and DA&D's sister agency, the Department of Prevention, Assistance, Transition and Health Access (PATH).

During every step of the development process, the Commissioner held discussions with the Department of Aging and Disabilities' Advisory Board at its monthly meetings. The DA&D Advisory Board will continue to function as the oversight board for this long-term care program. Meetings are always open to the public and many advocacy groups are represented either on the board or as regular guests at the board meetings.

Chapter 9: Waivers Requested

In order to operate the Demonstration described in this proposal, the State of Vermont will require the following waivers for statutory and regulatory requirements of the Title XIX Medical Assistance Program.

1902(a)(1) - The State requests a waiver of the Statewideness requirements set forth in the Section to permit it to offer different types of Home- and Community-Based Services in different geographic regions of the State.

1902(a)(10) – The State requests a waiver to enable it to provide non-Medicaid State Plan services to the Demonstration population.

1902(a)(10)(b) - The State requests a waiver of the Comparability requirements set forth in the Section to permit it to provide services to individuals served under the waiver that are not available to Medical Assistance recipients who are not enrolled in the waiver and to impose different levels of resources for persons electing home-based care.

1902(a)(10)(b) - The State requests this waiver to permit it to restrict the amount, duration and scope of services provided to a Demonstration enrollee to those services included on the approved Comprehensive Care Plan.

1902(a)(10)(C)(i)(III) - The State requests a waiver of this section to use institutional income and resource rules for the medically needy, with resource limits set at $10,000 for enrollees electing home-based services in lieu of nursing facility or other residential care services in licensed settings.

1902(a)(17) - The State requests a waiver of this section to enable it to consider only the individual's income and resources when applying for the waiver as a Moderate Needs group

member and to offer 1 month spenddowns for people receiving community-based services as an alternative to institutionalization. Additionally this waiver will permit the State to disregard quarterly income totaling less than $20 from the post-eligibility income determination.

1902(a)(23) - The State requests a waiver of this section to enable it to restrict freedom of choice of provider.

1902(a)(14) - The State requests this waiver to enable it to impose cost sharing on certain services.

1902(a)(34) - The State requests this waiver to permit it to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance in made under this Demonstration for Expansion eligibles.

1902(a)(32) - The State requests a waiver of this requirement to permit it to provide reimbursement, through tax credits granted by the Vermont Department of Taxes, to persons purchasing qualified individual long-term care insurance policies.

1902(a)(10)(A) and 1902(a)(10)(C)(I)(III) - The State is requesting these waivers to permit it to use streamlined eligibility procedures, along with streamlining the Medically Needy process, and include eligibility standards and requirements that differ from those required by law.

1902(a)(18) and 1902(a)(17)(b) - The State requests this waiver to enable it to develop standards (subject to CMS approval) that permit Vermont to count income that has been transferred, within 12 months prior to application for assistance or at anytime while receiving medical assistance, for less than fair market value, unless transferred solely for purposes other than to obtain or maintain medical assistance under the Demonstration.

1902(a)(4)(A) (as implemented by 42 CFR 431.804, 431.806(a), 431.810-431.816, 431.820-431.822 and 431.865 except that the regulatory definitions of “claims processing error” and

"state agency" shall continue to be applicable) – The State is requesting this waiver to enable it to employ a Medicaid Eligibility and Quality Control System that varies from that required by the cited statute.

The State also requests any additional waivers that CMS deems are needed to operate the demonstration, including any additional waivers necessary to include the non-State Plan services in the long-term care benefit package described in this proposal.

Also Vermont requests that the Secretary, under the authority of Section 1115(a)(2) of the Act, consider expenditures made by the State of Vermont for the items identified below (which are not otherwise included as expenditures under Section 1903) shall, for the purposes of this Demonstration and the period of this project, be regarded as expenditures under the State's Title XIX Plan:

- Expenditures to provide home- and community-based services to individuals who would not otherwise be eligible for Medicaid, because they are not at immediate risk of institutionalization absent the provision of the HCB services.

- The amount of individual tax credits provided to individuals purchasing approved long-term care insurance policies.

- Expenditures that would have been disallowed under Section 1903(u) of the Act based upon Medicaid Eligibility Quality Control findings.

- Expenditures for services provided by caregiver spouses approved by the State to provide care on a compensated basis.

- Expenditures for services provided during a period of presumptive eligibility.

Chapter 10: Implementation Plan

The Vermont Department of Aging and Disabilities will implement the proposed long-term care reform program in phases beginning July 1, 2004. Prior to that date, the State will put in place the infrastructure and systems required to administer the Demonstration. This chapter provides a brief overview of the State's timeframes and plan for implementing the Long-term Care Demonstration.

Pre-Implementation Activities

DA&D will undertake a number of activities in preparation for the implementation of the Demonstration. Those activities and their respective timeframes are presented in an overview of the State's Pre-implementation Work Plan at the end of this Chapter.

Phased Implementation

In the first phase, which will begin July 1, 2004, the State will enroll all existing long-term care recipients in the Demonstration program. The resource limit will be raised to $10,000 from $2,000 for persons found eligible and participating in home-based services after that date, with cost sharing for home and community based services for individuals with resources above $2,000. Cost sharing will be established on an annual basis and will range from $50-100 per month, depending on the enrollee's actual level of resources as determined at the time of eligibility determination or re-certification. Cost sharing shall be accomplished through the payment of co-payments.

Presumptive eligibility will be implemented in the first phase for individuals in the Highest Need group. Based on the outcome of that process over the first six months of the Demonstration, the presumptive eligibility process will be expanded to include those enrollees in the High Needs group.

The provision of services to persons in the Highest Need group will be the first priority of the program. Those enrollees will be eligible for all Core services based on medical necessity and individual circumstances, as specified in their individual plan of care. Enrollees in the High Needs group will have second priority status and will be eligible for Core services to the extent that funds are available beginning November 2004. The Moderate Needs group will have third priority status. At a minimum; however, enrollees in the High and Moderate Need groups will receive case management services. These enrollees will also have access to some level of homemaker and adult day services if their conditions and circumstances indicate that these services are essential to assisting them to maintain their independence in the community. (Full implementation of services for the Moderate Needs group will be in July 2005, assuming funds are available.)

During Phase I, DA&D will also "kick off" the Statewide Educational Initiative. This initiative will include a comprehensive campaign using multi-media approaches to providing information to the public about the long-term care programs and resources available in the State.

During Phase I, the Long-Term Care Ombudsman program will also be expanded from the current model, which serves residents in nursing facilities and residential care homes, to a more comprehensive initiative encompassing the full range of long-term care services.

During Phase II of the Demonstration, beginning July 1, 2005, enrollment will be expanded to include optional services for the Highest Need group and additional Core services for as many High and Moderate Needs group enrollees as can be sustained with the available funding. The precise level of service provision for the High and Moderate Needs groups will be based on available resources, with the members of the High Needs group being served first. A prioritization methodology will be used to determine which individuals will receive what level of services.

Finally, Phase II will also see the inclusion of the private long term care insurance initiative to encourage Vermonters to purchase long-term care insurance policies. It is anticipated that some

type of state tax incentive will be offered, as determined by the Administration and Legislature. During this phase the State will also expand the number of High and Moderate Need persons being served and add Optional services to the benefit package for these two groups, if funds are available under the waiver.

The table below shows the phase-in of the various components of the new long-term care program.

IMPLEMENTATION OF VERMONT'S LONG-TERM CARE 1115 WAIVER									
	July –Oct. 04	Nov. – Feb. 05	Mar. - June 05	July – Oct. 05	Nov. – Feb. 06	Mar. - June 06	July – Oct. 06	Nov. – Feb. 07	Mar. - June 07
Phase I									
Enroll current long-term care recipients	X →	→	→	→	→	→	→	→	→
Start presumptive eligibility for Highest Need Group	X →	→	→	→	→	→	→	→	→
Provide services to Highest Need Group	X →	→	→	→	→	→	→	→	→
Provide services (in addition to case management) to High Need Group, depending on available funds		X →	→	→	→	→	→	→	→
Provide case management services to Moderate Need Group	X →	→	→	→	→	→	→	→	→
Public Information/Educational Campaign	X →	→	→	→	→	→	→	→	→
Expand LTC Ombudsman Program to Home-Based Care		X →	→	→	→	→	→	→	→
Phase II									
Based on success in Phase I, implement presumptive eligibility for High Need Group				X →	→	→	→	→	→
Provide services to Moderate Need Group (in addition to case management and some adult day and homemaker services)				X →	→	→	→	→	→
Expansion of optional services for Highest Need group and Core services for as many High and Moderate Needs group enrollees as can be sustained with available funding				X →	→	→	→	→	→
Expand the number of High and Moderate Need enrollees and add Optional Services for these groups; earlier if funds allow				X →	→	→	→	→	→
Encourage Vermonters to purchase LTC Insurance policies				X →	→	→	→	→	→

Long-Term Care Demonstration Waiver
Summary of Pre-Implementation Work Plan

AREA	TASK	Estimated Completion Date
DA&D staffing/mgmt		
	Refine new organizational structure for 1115 Waiver management	12/1/03
	Develop job descriptions and file PER-10s for new positions and existing DAIL staff; request positions from Dept. of Personnel Position Pool	1/1/04
	Hire, orient, train new staff	4/1/04
	Set up space: home office or in regional offices. Purchase equipment: laptops, modems, printers, file cabs, phones, desks, etc.	6/1/04
	Ensure that computers have CITRIX capacity for secure connections	6/1/04
	Develop details of supervision/communication between Central Office and field staff	6/15/04
	Develop Memorandum of Agreement between the Department of Aging and Disabilities (DA&D) and the Department of Prevention, Assistance, Transition and Health Access (PATH) – (houses the State Medicaid Division)	4/1/04
	Update UR procedures and coordinate with the DA&D Division of Licensing and Protection (DLP)	4/1/04
	Develop short form assessment for initial Plan of Care (POC)	4/1/04
	Clinical eligibility- automate as much as possible, test and refine	6/1/04
	Financial eligibility- automate as much as possible, test and refine	6/1/04
	Develop waiting list/reporting procedures	6/1/04
	Develop encrypted email capacity between DA&D and regional staff	5/1/04
	Incorporate data from DAILCARE database (Waiver cases) into SAMS2000 database (comprehensive database for DA&D clients)	TBD
	Revise POC forms, print, distribute. Deliver training on new forms.	6/1/04

AREA	TASK	Estimated Completion Date
Interactions with Local Organizations		
	Finalize local/DA&D protocols for referrals, enrollment procedures, UR, Waiver Team meetings, sharing of client information via meetings with workgroup.	6/1/04
Regulations and Ongoing Oversight	Create workgroup and issue invitations and meeting schedule	10/1/03
	Define purpose and scope of regulations	11/18/03
	Draft regulations	2/1/04
	Distribute for public comment	2/15/04
	Revise regulations	3/15/04
	Promulgate through APA process	5/1/04
	Continue to use the DA&D Advisory Board meetings as the place where discussion and oversight occur	On-going
	Appeals: Clarify procedures for 4 types of appeals: clinical (program eligibility and group eligibility); financial eligibility; services included in the Plan of Care; and prioritization of waiting lists for High Need and Moderate Need groups	6/1/04
LTC financial eligibility		
	PATH and DA&D develop procedures for each eligibility group	3/15/04
	PATH ACCESS creates system codes for each eligibility group	4/1/04
	DA&D regional staff, case mgs/providers and trained on new procdures	6/1/04
	Presumptive eligibility procedures are developed	4/1/04
	DA&D staff, PATH staff and local case managers are trained on new procedures	6/1/04
	Strengthen current Estate Recovery Law to the extent possible	On-going

AREA	TASK	Estimated Completion Date
LTC clinical eligibility		
	Procedures developed for each group	3/15/04
	Application developed with integrated eligibility screens	4/1/04
	DA&D staff and local case managers and providers are trained on new standards	6/1/04
	Prioritization policies and procedures are developed to be used with Long Term Care team for High Needs group.	6/1/04
Financial systems: Payments, tracking, management		
	Administrative budget/plan developed	3/1/04
	Statewide and regional budget plans developed	4/1/04
	Methodology developed for determining whether all enrollees in the entitlement (Highest Need) group are being served. Develop process for determining if funds are available to serve persons in the High Need group and Moderate Need group. Establish methodology for allocating those funds by local area.	5/1/04
	New services/rates on file at EDS (Medicaid claims processing system)	6/1/04
	New Cash/& Counseling financial payment via Intermediary Service Organization is set up	6/1/04
	PATH ACCESS system (Medicaid eligibility tracking system) links to EDS for claims processing	6/1/04
	Develop new eligibility/payment mechanisms for Adult Day grants	3/1/04
	Grant agreements signed with Adult Day Centers	7/1/04
	Develop new eligibility/payment mechanisms for Homemaker grants	3/1/04
	Grant agreements signed with Adult Day Centers	7/1/04
	Move Social Service Block Grant (SSBG) funding into the Attendant Services Program (ASP); develop Medicaid eligibility tracking procedures for ASP	7/1/04

AREA	TASK	Estimated Completion Date
Training local staff (case managers and providers)		
	Meet with each LTC team re: new processes	5/1/04
	Revise team protocols; include Nursing Facility and Residential Care Home staff in the process	6/15/04
	Conduct bimonthly statewide LTC meetings	On-going
	Develop new policy/procedures manual and post on DA&D website	6/15/03 – changes on-going
Research/evaluation		
	Meet with CMS research and evaluation team to refine research questions and data collection methodologies	TBD
	Set up internal research team and data collection methodologies for research that DA&D is specifically interested in that might not be covered by the CMS researchers	5/1/04
	Analyze data and create reports	
	Proceed as instructed by CMS	TBD
Operational Protocols	Draft protocol and submit to CMS for comments	1/31/04
	Receive input from CMS and finalize document	3/1/04
	Post final Operational Protocol on DA&D website	3/15/04
QA/QI	Develop protocols and procedures based on work from the QA/QI workgroup and CMS guidance when available. Integrate procedures with exiting procedures in the Division of Licensing and Protection.	2/15/04
	Assign QA/QI tasks to DA&D staff	5/1/04
	Create standard review forms/documents	5/15/04
	Distribute protocols to local providers and post on DA&D website	6/1/04
	Implement new QA/QI protocols and procedures	7/1/04
	Continue DA&D consumer surveys	On-going
	Expand Ombudsman program to home-based settings	3/1/05

AREA	TASK	Estimated Completion Date
Public Information and Education		
	Meet with workgroup to define scope and approach	11/1/03
	Review existing materials for information and education.	12/1/03
	Develop plan for multi-phase/multi-media program	1/15/04
	Develop RFP and contract with social marketing firm, if determined necessary	3/1/04
	Implement Plan	4/1/04
Cash & Counseling Pilot	Workgroup and DA&D refine methodology for pilot – guidelines for use of funds; QA/QI specific to the pilot; evaluation criteria; consumer selection criteria; case management function; interaction with Intermediary Services Organization	2/15/03
	Select pilot area(s): develop criteria for selection; issue Request for Interest; select pilot site(s)	4/1/04
	Provide training to case managers	5/1/04
	Consumers selected and trained	6/1/04
	Pilot starts	71/04
	Evaluation and decision to expand initiative with any necessary course corrections	7/1/05